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ABSTRACT

Rehabilitation therapy education in Kentucky and articulation within the fields of physical therapy and occupational therapy are examined, based on the Kentucky Allied Health Project (KAHP). The KAHP's model system of allied health education promotes articulation in learning, planning, and resource utilization, and seeks to meet the needs of patients and students and to reduce the rising cost of health care. Phases of the KAHP include planning, developing and comparing curricula, reviewing articulation, initiating transfer agreements, developing a statewide articulation system, and project evaluation. For both physical therapy and occupational therapy, information is presented on: the history of the profession, types of educational programs, regulatory practices in the profession, and accreditation of the programs. Issues in articulation include identifying and establishing increased career mobility options for physical therapist and occupational therapist assistants. Activities of the Rehabilitation Therapy Discipline Advisory Group (DAG) of the KAHP include helping to reduce the extended time required for a physical therapist assistant to matriculate through the University of Kentucky (UK) program; and arranging for direct credit transfer from Jefferson Community College to the University of Louisville (UL) and UK programs. Additional DAG recommendations and the use of the Program Evaluation and Review Technique are addressed. (SW)

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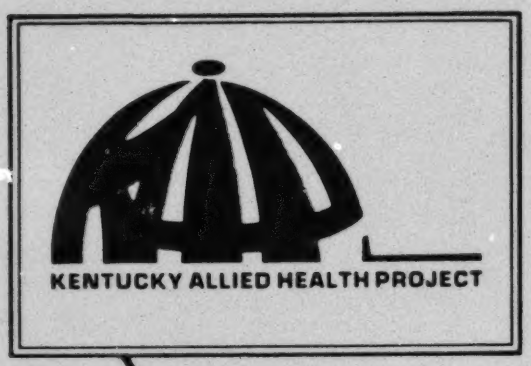

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HE 015 788

REHABILITATION THERAPY

STATE SYSTEM FOR ALLIED HEALTH EDUCATION

KENTUCKY ALLIED HEALTH PROJECT

REHABILITATION THERAPY

DISCIPLINE ADVISORY GROUP

FINAL REPORT

Commonwealth of Kentucky
Council on Higher Education
Frankfort, Kentucky 40601

Harry M. Snyder
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June, 1982

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SUMMARY

Discipline Advisory Group (DAG)

The Group established statements of their philosophies of articulation in physical therapy and occupational therapy in relation to the activities of their respective professional associations. Available curricula were outlined to focus on articulation and alternate courses which would enhance career mobility. A series of recommendations was generated which addressed the acceptability and possibility of articulation in physical therapy and occupational therapy, respectively. The background and rationale for the recommendations were based on the Group's discussions and investigation of the possibility of enhancing articulation in Kentucky. They finally concluded that the extent to which articulation existed was optimal given the professional indicators nationally and locally.

The scope of the Group was necessarily limited by the minimal number and levels of programs existing in Kentucky and, therefore, participating in KAHP. The results of the Group's activities were reflective of the fewer number of members in the Group compared to the other DAGs involved in the system. Simultaneous with KAHP, the American Physical Therapy Association and the American Occupation Therapy Association were both at varying degrees of completing role delineation studies in their respective discipline. Consequently, the Group did not feel they had an available, nationally accepted delineation of each profession. The members felt this was essential in developing articulated curricula but did not feel prepared to conduct their own studies. Therefore, the DAG accepted the current degree of articulation as most feasible for Kentucky at that point in time.

The Final Report of the Rehabilitation Therapy Discipline Advisory Group was submitted to the Allied Health Task Force for review in the Spring of 1981 and the DAG discontinued its meetings. Due to the conflict between the goals of KAHP and the DAG's view of the limited applicability of initiating a greater degree of articulation in the two disciplines, the Task Force responded with the recommendation that two (2) non-partisan evaluators review the Report and submit a response to the Task Force and the DAG. However, the DAG members collectively decided not to formally meet again and, thereby, did not respond as a group to the recommendations of the outside consultants. Improving the status of articulation, which was suggested as feasible by the consultants, remained questionable in terms of the DAG's desire and recognition of the need for more investigation into articulation in physical therapy and occupational therapy, respectively.

Articulation Committee

Subsequent to DAG activities a committee was convened of representatives from the Physical Therapist Assistant Associate Degree Program at Jefferson Community College and the (proposed) Physical Therapy Baccalaureate Program at the University of Louisville. Urged by the Council on Higher Education review process for new program proposals, the University of Louisville formed the committee to augment the proposal by documenting its commitment to articulation. Consequently, the members developed a transfer agreement to formalize the mechanism for qualified physical therapist assistant graduates to pursue upward career mobility.

Briefly, the agreement between Jefferson Community College and University of Louisville specifies 1) direct credit transfer, 2) advanced placement credit and 3) areas of cooperation:

1). Direct credit transfer may be awarded to eligible Jefferson Community College graduates for general education courses (26 credits) in english, psychology, biology, math and sociology; taken under advisement while at Jefferson Community College specified courses in chemistry (9 credits) and physics (10 credits) may be transferred to meet prerequisites for admission to the UL program.

2). Advanced placement credit may be awarded to Jefferson Community College graduates admitted to the University of Louisville program for courses totaling 14 credit hours toward the bachelor's program in physical therapy.

3). Additional areas of cooperation between Jefferson Community College and University of Louisville faculty include cooperative planning of clinical education experiences, exploration of teaching selected components in each other's program, jointly planning faculty/staff development meetings and developing an evaluation plan to determine the success of transfer students.

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Setting for the Project

The Kentucky Council on Higher Education, a statewide coordinating board, was awarded a grant in 1978 from the U.S. Department of Health and Human Services to develop a statewide system for allied health education. To adequately describe the development of KAHP, a brief description/definition of the purposes and functions of coordinating boards will be presented.

Kentucky Higher Education and Kentucky State Government are by necessity linked together, sometimes as adversaries, sometimes as partners. Sandwiched between the public colleges, universities and state government is the Kentucky Council on Higher Education, a statewide coordinating board.

The Council is one of the country's oldest higher education coordinating agencies (1934); however, until it was strengthened in 1966 and again in 1972, it had little authority with which to perform its coordinating responsibilities.

In the 1970's the Commonwealth, through the Council on Higher Education and with the full cooperation of the universities, took the initial steps toward the development of a system of higher education. A 1976 Council report, Kentucky and Comprehensive Planning for Higher Education, states:[1]

> Although Kentucky has a great variety of public institutions, they are not organized into a cooperative system through a coordinated balance of programs, through consideration of unnecessary duplication or overlapping responsibilities....

In 1977, the adoption of mission statements was aimed at organizing a system of higher education. The Council stated that the system was to promote "quality education and research, efficient use of resources, effective communications and smooth movement of students between institutions." The Kentucky Allied Health Project (KAHP) was conceived and designed as a sub-system within this total system. As a sub-system for allied health education, KAHP would strive for both efficient utilization of resources and the development of smooth movement of students between institutions.

The publication entitled "A System of Higher Education in Kentucky Including Mission Statements" presents several characteristics of this system.[2] Two characteristics which directly relate to the goals of the Kentucky Allied Health Project are:

1. "Centralized coordination of program offerings at all levels and among all institutions."
2. "Recognition of and program articulation with the vocational schools in implementing the 'career lattice' concept in post-secondary education."

For a statewide system of higher education to function smoothly, policy decisions must be made that support the characteristics of the system. Each institution must support the system's development. In a system of higher education, one of the central requirements is cooperation between and among institutions.

The Council's belief in and support of a higher education system provided the conceptual framework for KAHP. All curriculum decisions were entirely the responsibility of the cooperating faculty and institutions. In fact, because the Council views academic freedom as a universal and

absolute concept, the success or failure of KAHP was directly related to the institutional faculties. These faculties had to support the philosophy of articulation, be willing to engage in curriculum experimentation and to not only consider the needs of their respective institutions but the needs of the state as a whole. Some faculties did this with great success and a sense of commitment to students from all levels of higher education and all types or institutions (i.e., vocational, private, public, and proprietary); other faculties clung to professional and personal vested interests and were unable to respond to state and/or institutional needs.

The Council's willingness to respect and recognize the claims of academic freedom and procedural autonomy and the institution's equal willingness to recognize the state's right to participate in statewide planning for allied health education contributed to some of KAHP's success. These cooperative attitudes resulted from the fact that the formal structure brought the institutions and the Council together as partners in a joint venture firmly believing in shared group decision making and leadership.

Purpose of the Project

The purpose of the Kentucky Allied Health Project (KAHP) is to use the resources available to develop and implement a model articulated system of allied health education. The articulated system is viewed in the broadest sense to include articulation in learning (i.e., plans to permit a smooth transition from one education level to another) and articulation in educational planning and resource utilization. There are currently 105 allied health programs in Kentucky, seventy-two (72) of these programs are offered by the public sector. Allied health activities have significantly increased the interinstitutional cooperation and coordination among these programs.

Significance of the Kentucky Allied Health Project

Allied Health education programs in the 1960s underwent a significant growth phase fueled by federal monies from the Allied Health Professions Act of 1966. The funding stimulated the coalescence of many programs into schools of allied health professions in a collegiate or university setting. These schools expanded their student enrollments to fill the proliferating programs which represented a response to the nation's diverse health manpower needs.

However, curtailment of direct federal funding coupled with greater governmental demands for fiscal accountability in the late 1970s and early 1980s led to such events as program moratoria and a closer scrutiny of the fundamental goals and objectives of these schools.

While the development of allied health education has been characteristically segmented, the impact on the management of education for the 1980s mandates activities that are collaborative and articulated. Can allied health education in Kentucky, faced with such driving forces as shrinking economic resources, demands for accountability in costs, productivity and outcomes and changes in major technologies, meet these challenges?

In an attempt to meet these challenges, the Commonwealth of Kentucky has proposed the development of a statewide system for allied health education. This system interlocks segmented educational components into a comprehensive structure. The system is based upon three major social concerns:

(1) The concern to meet the needs of the patient.

Many driving forces are pressing for new approaches to allied health education which will culminate in a comprehensive system of care for the patient. If the goal of comprehensive care is to be

achieved, there must be meaningful collaborative arrangements.

(2) The concern to meet the needs of students.

Students are seeking mechanisms for career mobility. A system of allied health education must be developed to help meet these needs. Much of the research on vocational choice and career mobility strongly support a flexible system of education with several entry and exit points. The goal of Kentucky's system of allied health education is to eliminate any unnecessary duplication or artificially imposed barriers that inhibit the ability or motivations of the individual.

(3) The concern to slow the spiraling cost of health care.

Allied health education cannot continue to operate oblivious to the cost to the patient. Allied health educators must recognize and find solutions to the problems of (1) eliminating unnecessary program duplication, (2) avoiding overtraining in terms of functions performed, and (3) improving the effectiveness and efficiency of programs.

In summary, the Kentucky Allied Health System is based upon three major social concerns: (1) the goal of comprehensive care for the individual, (2) the educational needs of the students, and (3) better utilization of existing resources.

Several barriers make the task of developing a system for allied health a difficult one; barriers created by curricula, educational institutions, health care facilities, and laws and state government agencies. However, perhaps the most formidable problem is overcoming professional biases. The temptation to exercise territorial imperatives is understandable. However, our greatest success occurred when educators philosophically believed in career mobility. In contrast, our greatest failures occurred when educators did not hold this philosophy and carefully guarded their "territory." To a

very real extent, philosophy and territoriality retarded progress.

Perhaps the significance of KAHP is that a system has been developed considering:

What is best for the patient?

What is best for the student?

How can a system of allied health education be developed that is highly efficient and integrated?

Organization of KAHP

Six phases were designed to meet KAHP's major objective of developing and implementing a statewide system of articulated allied health education. These phases are summarized in Table 1.0.

Table 1.0.

Phases of the Kentucky Allied Health Project

Phase I	Phase II	Phase III
Literature Review Manpower/Program Data Program Directory Evaluation Design Task Force	Six Discipline Advisory Groups Evaluation and Research Technical Advisory Group Role and Function Delineations Curriculum Reviews Manpower Models	Model Curricula Potential Articulation Designs Transfer Agreements Drafts System Recommendations
Phase IV	**Phase V**	**Phase VI**
Transfer Agreement Negotiations	Final Articulation Designs Articulation System Preparation Recommendations to CHE for Action	Statewide System Project Evaluation Articulation System Monitoring

To develop a model for statewide planning in allied helath education, six disciplinary clusters were chosen. These clusters include: (1) clinical laboratory sciences, (2) dental auxiliaries, (3) nutrition/dietetics, (4) radiological sciences, (5) rehabilitation therapies, and (6) respiratory therapy. All levels of programs within each discipline cluster which existed in Kentucky were included in the system.

Phase I: Planning

KAHP's planning was accomplished by several individuals and groups working in concert providing a rich interplay of ideas and abilities. In the planning phase, the staff began a literature review to determine if similar efforts had been made, their strengths and weaknesses, and their relevance to KAHP. In addition, the staff began to synthesize relevant manpower and educational program data. The merging of allied health manpower data and educational program data was viewed as essential for statewide planning. While the Council collected information regarding public higher education, a complete directory needed to include private education, vocational education, hospital-based programs, and proprietary programs. Consequently, the first planning task was to complete a statewide inventory of allied health education programs. This inventory provided the basis for activating the discipline advisory groups for Phase II.

The establishment of an overall project evaluation design was also completed in Phase I. The planning and evaluation procedure known as Program Evaluation and Review Technique (PERT) was selected to provide continuous program evaluation of progress toward the achievement of predetermined objectives.[3]

A final activity in Phase I was the activation of the Allied Health Task

Force in May, 1979. The fifteen (15) member Task Force was composed of representatives from the public colleges and universities, independent colleges and universities, vocational schools, practicing clinicians, and hospital administrators. The primary objectives for the Task Force were to provide general coordination for the project and help secure support for the project from essential publics.

Phase II: Developing and Comparing Curricula

The first step for Phase II was to activate the six discipline advisory groups in September, 1979. The membership for these six advisory groups was recommended by the Allied Health Task Force. Each group was composed of approximately 15 members (a total of 90 individuals). These individuals were chosen to represent public and independent colleges and universities, vocational schools, proprietary schools, hospital-based programs, practicing clinicians, and professional organizations. (See Figure 1.0.) The central concept used in selecting these advisory group members was that those individuals responsible for implementing project recommendations should assume key leadership positions in developing the recommendations. It was also the project staff's basic belief that there should be shared responsibility between educational institutions and the statewide coordinating board for planning a system of allied health education.

In addition to the activation of six discipline advisory groups, the project was also assisted by an Evaluation and Research Technical Advisory Group. The primary objectives of this group were to (1) develop the methods

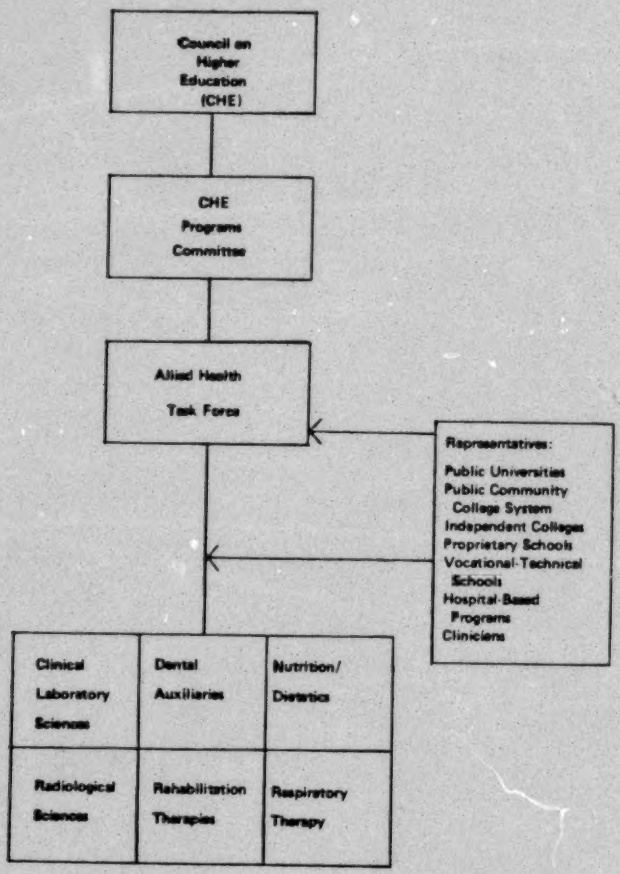

Figure 1.0. Organizational Structure of the Kentucky Allied Health Project

and instruments for the evaluation and implementation phase of the project, (2) review a competencies research model for use by two discipline advisory groups, (3) develop a manpower projection model, (4) develop a graduate follow-up model, (5) develop a program cost assessment model, (6) develop a practitioner profile component, and (7) guide data collection and analysis.

A major activity in Phase II was the delineation of roles and functions for each level of practice within each allied health profession and the identification of competencies by level with the goal of developing curricula. This task was seen as an essential prerequisite to the design of articulation models. Each discipline advisory group approached the delineation of roles and functions differently depending on the success of their respective professional associations.

The Respiratory Therapy and Nutrition/Dietetics groups chose to use the Health Services Mobility Study (HSMS) Method of Task Analysis and Curriculum Design [4] since neither group had an acceptable and comprehensive delineation of their practices. The Clinical Laboratory Sciences group validated competencies that had been developed by their professional society. The Dental Auxiliaries group chose to utilize the roles of dental auxiliaries as specified by the Kentucky Dental Practice Act. While they realized that roles may vary by state, they chose to develop an articulation model that could work within Kentucky.

The Radiological Sciences group was represented by several similar but yet unique professions (i.e., radiography, radiation therapy, nuclear medicine, and radiation health). This group approached the delineation of roles and functions on separate but parallel paths. Each discipline in the cluster used existing resources to finalize their curricula.

While each discipline advisory group was developing a curricula that contained the information needed for safe, competent professional practice, they also gathered program-specific information such as course outlines, clock hours, percentage of lecture, lab/and/or clinical components per course, minimal acceptable grades and the pre-professional and professional components of each curriculum. The data provided the fundamental information to begin planning the early phases of transfer negotiations.

Another major activity in Phase II was the development of a resources/ requirements model for each discipline for the purpose of manpower projections. The manpower data is essential information when considering the establishment, expansion, continuation, or termination of allied health programs. Three manpower models will be applied to the five allied health disciplines studied in KAHP. The models are: (1) manpower-population ratio, (2) trend analysis based on time series, and (3) health needs. Based on the manpower models KAHP completed for physical therapy [5] and respiratory therapy, [6] data are being collected to complete the clinical laboratory sciences and radiological sciences manpower models. While the limitations of making manpower projections are recognized, the information added another dimension to statewide planning efforts.

Phase III: Articulation Review

Joint meetings between the Discipline Advisory Groups and the Allied Health Task Force were held in the early summer of 1981. Together the groups (1) reviewed developed curricula, (2) reviewed the articulation designs within each discipline, (3) discussed recommendations for implementing and finalizing draft articulation agreements, and (4) discussed recommendations for implementing, monitoring, and evaluating the system.

These joint meetings provided an opportunity for the groups to share

not only their products such as curricula and draft transfer agreements, but also to discuss broader and less measurable outcomes of the process.

For example, the Task Force representative from vocational education shared the following:

> When the vocational education administrators asked the vocational faculty to participate on this project they agreed, but with little enthusiasm. However, their efforts resulted in the development of mutual respect between vocational education faculty and higher education faculty in the state. In addition, it enhanced communication within vocational educational programs. As a result of this communication, curricula were revised and strengthened. Furthermore, the vocational education faculty feel kinder toward higher education than they have in the past. Previously, they had felt like second class citizens in higher education. They emerged feeling that they were partners or co-equals. Consequently, they felt good about themselves and their programs. We have better vocational education programs because of their efforts.

Phase IV: Developing and Negotiating Transfer Agreements

After the joint meeting(s) of the Discipline Advisory Groups and the Task Force, mini-meetings were planned with selected Task Force members and faculty to help plan for the implementation of some of the transfer agreements.

Competency-based education was used as the theoretical framework for developing and negotiating transfer agreements. Types of agreements included the block credit transfer agreement and the course specific transfer agreement. Agreements were negotiated between educational systems and between specific programs/institutions.[7]

Phase V: Preparing the Articulation System

The primary activities in this phase included (1) final preparation of discipline specific articulation designs and (2) the preparation of a comprehensive statewide articulation system. Throughout the project the Task

Force had a major responsibility in the formulation of recommendations for a statewide system. These recommendations will go to the Council's Programs Committee and then to the Council on Higher Education for action.

Phase VI: Evaluation and Revision

Two primary evaluation components were planned: (1) evaluation of the project's ability to meet its stated objectives and (2) recommended procedures for evaluating the ability of the implemented system to facilitate the entry into and exit from an allied health educational program by capitalizing on student's previous relevant education and experience (i.e., ongoing monitoring of the success of the transfer agreements.)

KAHP's Approach to Leadership.

This section is included to share with others the philosophy upon which the group meetings were planned. In addition it will explain the evoluntary developments in terms of group process. Particular emphasis will be placed on the importance of group centered leadership and leadership as a shared function. It is hoped that by sharing these intimate relationships others will be encouraged to participate in similar endeavors.

Traditional views of leadership: (1) focus on the group's task; (2) the leader directs and controls; (3) the feelings and emotions of group members are not recognized; (4) the leader assumes full responsibility for decisions; and (5) the task becomes more important than individual needs.

These traditional views of leadership were abandoned. KAHP staff viewed leadership as "Group Centered Leadership." While fully recognizing the importance of the task of developing a statewide system for allied health education, we also recognized that member interactions and the emotional

reactions of individuals would have a profound effect on the successful completion of our task.

Consequently we viewed leadership as service. Such service included 1) helping the group develop a trusting climate, 2) encouraging members to freely express their feelings and 3) assisting members in accomplishing their task.

Leadership was not something that just the designated project staff members did. Leadership was shared with all members of the group. By recognizing that leadership was a group responsibility, it was also recognized that success or failure would be equally shared by all group members. This concept of shared group leadership was important because it recognized that no one person could possibly be simultaneously aware of all the group-maintenance tasks, group-building tasks, and individual problems existing at any given moment within the group. Such awareness must be shared by all members of the group.

In summary, our belief in group centered leadership was based on the assumptions that: (1) the meetings were owned by the members; the KAHP staff was a helper to the group; however, the group was responsible for all major decisions; (2) members not only shared ownership, but responsiblity for completing tasks; (3) feelings, emotions, conflict were recognized as legitimate; and (4) the needs and feelings of all members were viewed as important.

With this as our philosophical framework, we observed each discipline advisory group work through three stages of group development.[8] Stage one considers orientation, hesitant participation, and search for meaning. Our orientation meeting held on September 6, 1979 provided the setting for stage one "Goblet issues". During this stage group members size each

other up through discussion of nonemotionally laden topics. The term comes from cocktail party type communication where each guest sizes up the others by looking through a cocktail "goblet".

At this meeting Dr. Joy Kirchner, who had written the project grant, described the historical foundation for the project. Project objectives were described along with the roles of the discipline advisory groups and the project staff. Also at this meeting a group process activity called "Self Portrait" was completed. The self-portrait activity was planned to help promote positive relationships among and between discipline advisory group members and project staff. The advisory group members and project staff were asked to draw a story of their lives on a large piece of paper and share this story with the other members of the groups. While on the surface this appears to be a relatively unsophisticated procedure, it provided a successful way to meet one another fairly quickly. Hopefully, it assisted in the development of an accepting environment within which the groups could work during the coming year.

In stage two, issues regarding dominance, control, and power emerge. Hostility to the "leader" may also emerge as the group members realize that the "leader" is not perfect. We found that some meetings were not as effective as others; some advisory groups willingly shared all their available resources, (i.e., curricula, admissions policies and student success/failure rates) while other groups found it difficult to share. Democracy takes time; the price of group decision making and consensus is time, trust, and openness. Futhermore, tradition seemed to inhibit meeting effectiveness. For example, the older more established professions such as clinical laboratory sciences and the rehabilitation therapies had much more difficulty planning sequences of transfer, especially for the professional courses within the curricula. In

contrast, respiratory therapy found the task less cumbersome. However, at no time during stage two did we feel overt hostility.

In stage three group members began to have concerns about intimacy and closeness. As the groups began to be able to more freely address their positive and negative feelings, they became more cohesive and mature. This maturity was characterized by the following:

(1) Serious involvement in activities

As the members began to feel a sense of ownership and involvement in their tasks, they assumed greater responsibility for such activites as report writing and team building.

(2) Trust and caring

The trust and caring that emerged in some groups allowed the members to express concerns, feelings, fears, and ideas.

(3) Accepting new members

It was recognized that group membership would always be in the process of change, adding new members and losing old ones. However, new members were accepted and seen as a potential resource.

The previous description basically describes the work of the five discipline advisory groups that were viewed as somewhat or very successful. However, not all our discipline advisory groups were successful; and we would like to briefly try to present a rationale for why one group failed. A successful group interacts over time to accomplish one or more goals that are valued by each of the participating individuals.[9] The physical therapy advisory group's philosophy statement stated that there was currently no organized effort on the part of the physical therapy profession to facilitate the upward mobility of the physical therapist's assistant within the profession. Mirroring this philosophy, physical therapy's support of transfer for the assistant was

somewhat less than whole hearted.*

As a result the project goals were in conflict with the goals of the physical therapy advisory group members. Because upward mobility for the assistant was not "valued" by this group, the project's objectives for this group were not achieved. This was further reinforced to us by such statements as - "I don't feel its appropriate for this group to do more at this time." "Prove there is a need for articulation by a statistical study." "We met our objectives a long time ago, when we stated articulation was not appropriate at this time" " I would prefer if the project were terminated."

To summarize, no matter how competent the group leader or how many resources are available in terms of time and money, if the group does not highly value the goals, the group will fail.

To conclude we would like to offer a number of suggestions that may be useful to newly formed groups that have as their goal the development of articulation agreements:

(1) Develop an awareness for the interdependent behaviors that must be performed by group members.

Task behaviors are those behaviors that are related to achieving the groups goals such as giving suggestions or directions and seeking information. Maintenance functions are those behaviors related to maintaining harmonious relations among members such as helping, rewarding, relieving tension by joking, and showing satisfaction. Both task behaviors and maintenance behaviors are equally important.

*While the Rehabilitation Therapy DAG did not develop an articulation model that transferred professional course credit, an articulation agreement between the Physical Therapy Program at the University of Louisville and the Physical Therapist Assistant program at Jefferson Community College was developed after the Rehabilitation Therapy DAG decided to discontinue meeting.

(2) View leadership as a shared group function.

By viewing leadership as a shared group function, all members are encouraged to contribute and the sharing of leadership ensures that all the resources of the group will be used productively.

(3) Willingly accept new members.

While a high turnover of group membership may indicate that something is seriously wrong within the group, some turnover is natural. Welcome each new group member as a valuable resource.

(4) Allow "hidden agendas" to surface in open discussion.

Hidden agendas occur because an individual believes that the item may be judged as wrong or inappropriate, rather than as a reflection of a legitimate need or purpose. Remember, group members may be trying to simultaneously achieve individual and group goals. Often the degree to which both goals can be achieved determine the success of the group. Recognize that members may bring a hidden agenda to the group--one they hesitate to share openly because it is so self-oriented. Allow hidden agendas to surface in open discussion so that personal needs may be handled without disturbing the group.

(5) View conflict as natural.

Most substantive issues will involve some conflict. View this conflict as natural and indeed inevitable. Conflict worked through constructively can provide an important success experience for the group. Furthermore, it will reduce the fear of conflict and further strengthen the group.

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PHYSICAL THERAPY

Definition (From American Physical Therapy Association.)

Physical therapy is a health care profession which develops, coordinates and utilizes selected knowledge and skill in planning, organizing and directing programs for the care of individuals whose ability to function is impaired or threatened by disease or injury.

Employment opportunities are available in a variety of settings including departments of physical therapy in general or specialized hospitals; schools for crippled children; physicians' or physical therapists' offices and clinics; longterm care hospitals and nursing homes for the chronically ill or elderly; community and governmental agencies providing health services; rehabilitation centers; home health agencies; research centers; the Armed Forces; and in colleges and universities offering educational programs for physical therapists and physical therapist assistants.

Physical therapy incorporates a broad spectrum of activities such as direct patient care, consultation, supervision, teaching, administration, research, and community service. It also accepts responsibility for education

at many levels, recruitment of personnel, professional and ethical standards of practice, and for the welfare of patients and its own members.

There are three officially defined levels of physical therapy practitioners:

(1) the professional qualified physical therapist,

(2) the physical therapist's assistant, and

(3) the physical therapy aide.

Physical Therapist. The physical therapist is a health practitioner who develops, coordinates and utilizes selected knowledge and skill in planning, organizing, and directing programs for the care of individuals primarily with impaired function related to the neuromusculoskeletal, pulmonary, and cardiovascular systems focusing on the selection and application of appropriate therapeutic procedures and the appraisal of the results of treatment.

Evaluation includes performing and interpreting tests to assist in differential diagnosis, and to determine the degree of physical impairment. Evaluation provides the basis for the selection of appropriate therapeutic procedures and the appraisal of the results of treatment.

Therapeutic procedures include exercises for increasing strength, endurance, coordination, and range of motion; stimuli to facilitate motor activity and learning; instruction in activities of daily living and the use of assistive devices; and the application of physical agents to relieve pain or alter physiological status.

Physical Therapist Assistant. The physical therapist assistant is a skilled technical health worker who assists the physical therapist in patients' treatment programs and in other activities necessary to the operation of a physical therapy service as assigned by the physical therapist. He/she has graduated from a two-year college program with an associate degree in physical therapist assisting.

Activities of the physical therapist assistant include: 1) assisting the physical therapist in determining the physical therapy needs of any patient referred for treatment by gathering data, 2) applying designated treatment procedures in a manner that reflects an understanding of each patient's status (i.e. physical, emotional, cultural and socio-economic), 3) recognizing and responding to acute changes in the patient's physiological and emotional state and 4) functioning as an effective health care provider within the community and the health care system.

Physical Therapy Aide. The physical therapy aide is a nonlicensed worker at least 18 years old who has completed an on-the-job training program in a hospital or clinic facility. The physical therapy aide's primary function is to perform designated routine tasks related to the operation of a physical therapy service, but may assist with patient related activities which are predetermined for each patient and assigned by the professional physical therapist. The aide works under the supervision of a professional physical therapist.

History of Physical Therapy

The discipline of physical therapy is over sixty years old. The American Physio-therapy Association (now American Physical Therapy Association (APTA)) was recognized in 1934 and in conjunction with the American Medical Association (AMA) established minimum standards for training programs and conducted program accreditation visits. The standards were termed "Essentials of All Accredited Educational Programs for the Physical Therapist." The formal, collaborative efforts between APTA and AMA lasted until 1976 when APTA was recognized by the Department of Education (DE) and the Council on Postsecondary Accreditation (COPA) as an independent accrediting body for physical therapy.

The evolution of physical therapy since before 1920 followed the steps to

professionalization other disciplines have also followed. Practitioners were first trained through on-the-job apprenticeships which changed to nine month certificate programs. After this initial phase, practitioners sought more status establishing more rigid qualifications for practice through twelve month programs resulting in baccalaureate degrees. From the late 1950's master's level programs have been available for entry into practice. Today the thrust is toward requiring postbaccalaureate degrees for entry into practice.

The professional growth in status, numbers and qualifications of physical therapy practitioners has been a long progression of changes and challenges.

Two levels of credentialed manpower exist: 1) Licensed Physical Therapist (LPT), and 2) Certified Physical Therapist Assistant (CPTA). The CPTA, a newly created manpower level was identified in 1967. Uncredentialed personnel employed in hospitals are "physical therapy aides" who have completed on-the-job training programs in hospitals or clinics. There appear to be a number of aides employed in hospitals, however, they range in function from porter to uncertified assistant.

Physical Therapy Education

There are several patterns of education leading to professional qualification in physical therapy. All programs include general college requirements as well as professional education which includes basic health sciences, clinical sciences, and supervised administration of evaluative and therapeutic procedures.

1.) The bachelor's degree programs in physical therapy require four years for completion and take place in an approved college or university. There are two bachelor's degree program in physical therapy in Kentucky at the University of Kentucky Medical Center and the University of Louisville. (See Appendix B.)

2.) The certificate programs require a bachelor's degree in a field related

to physical therapy and fulfillment of certain science requirements for admission. It is generally a 12 to 16 month course and upon completion of the program a certificate is awarded. Graduates of certificate programs are considered equally as qualified as graduates of bachelor's degree programs.

3.) The master's degree programs require a bachelor's degree in a related field for admission and usually last two years. Upon graduation, the recipient of a master's degree usually finds employment in a teaching, supervisory or administrative position.

4.) Physical therapist assistant programs are located in community or junior colleges accredited by the appropriate regional accrediting agency. The two-year course of study includes biological, physical, and social sciences, humanities, physical therapy technical courses, and clinical experience. Graduates receive an associate degree as a physical therapist assistant. There is one associate degree program in Kentucky at Jefferson Community College.

5.) The physical therapy aides are on-the-job trained in a hospital or clinic-based program.

Of special interest is the policy adopted by the 1979 APTA House of Delegates on entry-level education in physical therapy. The resolution "was important in determining educational philosophy for the Association and the profession" (Grossman, 1980). The resolution mandates "that entry level education for the physical therapist be that which results in the award of a post-baccalaureate degree." The APTA Board of Directors has been charged to study the implications of implementing the post-baccalaureate entry-level policy by December 31, 1990.

Regulatory Practices in Physical Therapy

State licensure boards examine, license and certify physical therapy personnel in all fifty states. A Licensed Physical Therapist (LPT) is licensed

by the Kentucky State Board of Physical Therapy after having successfully completed a bachelor level physical therapy program approved by the American Physical Therapy Association and passed the written state board examination. Annual automatic license renewal occurs upon payment of a fee. Reciprocal licensure exists with other states and foreign countries. The license is subject to refusal, revocation and suspension.

The Certified Physical Therapist Assistant (CPTA), must graduate from a two-year college program approved by the American Physical Therapy Program with an associate degree in physical therapist assisting and pass the written state certifying examination. Recertification occurs annually after payment of a renewal fee.

Accreditation of Physical Therapy Educational Programs

The American Physical Therapy Association from its beginning has been actively concerned about and involved in accreditation of physical therapy education programs. Early in its history the Association tried to evalute on its own the quality of physical therapy education and to set standards for the education programs. Primarily because of limited financial and manpower resources APTA decided to ask AMA to help with the accreditation of education programs. In 1936 the two agencies joined in a collaborative arrangement for physical therapy education accreditation.

The collaboration continued until December 1976 when the APTA terminated the arrangement because APTA and AMA were unable to reconcile fundamental differences in philosophy related to physical therapy education. Following this the APTA petitioned the Council on Postsecondary Accreditation (COPA) and the Department of Education (DE) for recognition as an agency to accredit physical therapy education programs. The Committee on Accreditation in Education (CAE) of APTA was recognized by both bodies. The initial recognition of CAE-APTA

by COPA and DE have recently been renewed. COPA's recognition of CAE-APTA is subject to renewal after two years ending in December 1982, and DE's current authorization extends for four years until December 1984. AMA's Committee on Allied Health Education and Accreditation (CAHEA) had its recognition by COPA extended for two years at the same time CAE's recognition was continued. The CAHEA is no longer recognized by DE (Clinkinbeard, 1981).

Mobility and Articulation in Physical Therapy

The main issue in physical therapy articulation is to identify and establish increased career mobility options for the physical therapist assistant. The question has been raised whether or not "the physical therapist assistant program is an effective step for entry into the baccalaureate program" in physical therapy. It would appear logical based on principles of teaching and learning that students who complete an associate degree should be able to pursue career mobility within the same profession without having to repeat prior learning experiences. While programs are generally not designed to directly accommodate the assistant's advancement, sound educational planning and evaluation would appear to mandate attention to the issue.

The following statement was written by the physical therapy members of the Discipline Advisory Group (1979-80).

> At this time there does not appear to be an organized effort on the part of the physical therapy profession to facilitate the upward mobility of physical therapist's assistant within the profession. The American Physical Therapy Association has not taken a formal stand on the desirability of articulation between physical therapist's assistant and physical therapy programs.
>
> Historically, the profession's support for the development of the PTA has been somewhat less than whole hearted. It appears that the development of the PTA resulted from a desire to insure the quality of physical therapy services and, also, in response to external pressure for this level of supportive personnel. The need for this individual was not universally accepted by the profession.

Subsequently, when programs were developed for PTA's, they were not intended to be access routes to the profession. The profession at large tends to identify the PTA as an individual who has chosen the role of the assistant and is not necessarily seeking upward mobility. The primary goal of the PTA curriculum is to provide the learner with the technical skills associated with rendering physical therapy services.

Although the potential exists to award credit in a physical therapy program for prior academic experience, there is little inherent value in the process. In no instance would a student be able to "test-out" of an entire course, and exempting students from small selected sections of a course would result in a loss of continuity and the real possibility of missed information. Finally, although the students course load might be decreased slightly it would not alter the length of time spent in the professional physical therapy curriculum.

It is questionable that with modification of the present PT and PTA curricula (at the University of Kentucky and Jefferson Community College, respectively) that articulation will be enhanced. Possible sequellae or such modification could:

1. Create a PTA curriculum that is unnecessarily difficult for the majority of entrants. This is especially pertinent since so few of the graduates from the PTA program at Jefferson Community College have sought an advanced degree.

2. Create a PTA curriculum in excess of the four (4) semesters traditionally associated with a Community College degree.

3. Create a PT curriculum unsound due to having to accommodate multiple academic and technical backgrounds. This is especially true when you consider the impact of PTA's trained out-of-state, attempting to obtain credit for prior course work.

4. Create a PT or PTA curriculum that may not be in compliance with the standards for accreditation adopted by the APTA OR CAHEA.

The resolution adopted by the APTA 1979 House of Delegates requiring entry-level education be achieved through a post-baccalaureate degree clearly implicates the PTA's tenuous status in career mobility.

As a result of this statement several questions arise from the standpoint of responsible, statewide planning and coordination. Implications for sharing resources and remaining accountable to essentials publics in a time of economic austerity are among the challenges in physical therapy education.

OCCUPATIONAL THERAPY

Definition (From the American Occupational Therapy Association)

Occupational therapy is the art and science of directing man's participation in selected tasks to restore, reinforce and enhance performance, facilitate learning of those skills and functions essential for adaptation and productivity, diminish or correct pathology and to promote and maintain health. Reference to occupation in the title is in the context of man's goal-directed use of time, energy, interest and attention. Its fundamental concern is the development and maintenance of the life span, to perform with satisfaction to self and others those tasks and roles essential to productive living and to the mastery of self and the environment.

Since the primary focus of occupational therapy is the development of adaptive skills and performance capacity, its concern is with factors which serve as barriers or impediments to the individual's ability to function, as well as those factors which promote, influence or enhance performance.

Occupational therapy provides service to those individuals whose abilities to cope with tasks of living are threatened or impaired by developmental deficits, the aging process, poverty and cultural differences, physical injury or illness, or psychologic and social disability.

History of Occupational Therapy

The American Occupational Therapy Association (AOTA) was first founded in 1917 as the National Society for the Promotion of Occupational Therapy. This society endorsed occupational therapy concepts formulated from the theory that "man, through the use of his mind and body, can influence the state of his health."

Minimum requirements for training in occupational therapy were established

as early as 1923 which integrated clinical as well as didactic courses. The Essentials for accredited programs in occupational therapy evolved from a focus on course content and numbers of credits to an emphasis on program outcomes (i.e. graduates' ability to perform in various work settings.) These Essentials were a collaborative effort between AOTA and the American Medical Association.

A national registration exam, established in 1947, was the beginning of the AOTA national certification process. Currently, options for recertification of occupational therapists (vs. lifetime certification) are under investigation by AOTA to assure continued competence of occupational therapists.

Occupational therapy assistants were recognized such that in 1958 minimum requirements in training were established for assistant level personnel. "The Career Mobility Plan" offered by AOTA to provide the opportunity for Certified Occupational Therapy Assistants to enhance their knowledge of and skill in occupational therapy without returning to an academic setting. Thus career mobility was formally integrated into occupational therapy from the early 1970's.

Occupational Therapy Education

The registered occupational therapist (OTR) has completed an accredited four-year baccalaureate degree program and six to nine months of field work experience. There is one such occupational therapy program in Kentucky at Eastern Kentucky University. The OTR may have spent the full four years in an occupational therapy program, or may have transferred to occupational therapy after two years in a liberal arts program. Course work includes the physical, biological and behavioral sciences, and is followed by supervised field work experience dealing with conditions that are commonly met in practice.

For the person who already has a baccalaureate degree in an area other than occupational therapy, entry-level master's programs are available. Some schools may require post-baccalaureate students to have credits in human

growth and development, psychology, sociology or anthropology. The master's programs require about 45 semester credits plus six to nine months of field work experience.

The certified occupational therapy assistant (COTA) is a high school graduate or the equivalent, who has completed an approved two-year program in occupational therapy assisting. Course work focuses on human physiology, the task and skills used in daily life, and includes at least two months of supervised field work.

Following completion of course and clinical work, the entry-level OTR or COTA candidate must pass a national certification examination to obtain the credentials to practice.

Accreditation of Occupational Therapy Educational Programs

Guidelines for accreditation of educational programs for the occupational therapist are established and adopted by the American Occupational Therapy Association (AOTA) Commission on Education. The AOTA Accreditation Committee then, uses the criteria in the accreditation of baccalaureate level programs. These Essentials are developed in collaboration with the Committee on Allied Health Education and Accreditation (CAHEA) of the American Medical Association.

Similarly, Essentials of approved educational programs for the occupational therapy assistant are established and adopted by the AOTA Commission on Education and utilized by the Accreditation Committee. The approval of occupational therapy assistant programs is a voluntary process providing a means of evaluation and public accountability, as does the required accreditation procedure for baccalaureate and master's programs.

Regulatory Practices in Occupational Therapy

National certification has been endorsed by the American Occupational

Therapy Association as the most appropriate mechanism to assure the competence of its practitioners. State licensure is viewed by the profession as a limiting factor in career mobility but does exist in many states. "As a rule, the licensing requirements are similar to the AOTA's certification requirements. In those states not having licensure laws, definitions may not be uniform; individuals may refer to themselves as occupational therapists, although they do not meet the standards required of registered occupational therapists. To encourage enactment of state licensure programs, the AOTA's Government and Legal Affairs Division has prepared a Model Occupational Therapy Practice Act" (Langwell, et. al., 1981)

American Occupational Therapy Association Statement on Career Mobility

Society is increasingly concerned with the provision of both the quantity and the quality of services to meet the growing demands of health care. As a profession, occupational therapy recognizes the right of the individual to receive high quality health care and joins other professions in seeking solutions for improving the profession's contribution to the total health care system.

The American Occupational Therapy Association strongly supports the study and implementation of career mobility within and among the health professions as one means of increasing the supply of qualified personnel to meet the needs of the health care delivery system. "Mobility" is synonymous with the concept of career laddering and latticing. This concept proposes that an individual may enter a health care profession at one level in a related field, and then may transfer laterally to another profession or advance vertically in the original field. If such a concept is to be realized, effective integration of learning in preparation for the health professions must be accomplished.

Proper implementation of a core curriculum permits acceptable movement between the health professions while fostering an understanding of each service by the other. Preparation for working together by learning together can be a positive step toward the provision of more effective health care.

Equivalency mechanisms and proficiency examinations are valid approaches to career mobility so long as basic standards of competency and quality of care are not endangered. Curriculum directors should utilize these approaches by thorough but flexible evaluations of transfer credits from other educational institutions, of learning achieved through work experience, and of performance skills gained in other non-traditional ways.

The American Occupational Therapy Association advocates participation in research studies with relevant health professions to plan and implement integrated curriculums to encourage mobility and supports cooperative ventures to explore other possibilities and implications of mobility.

As evidence of commitment to the concept of career mobility, the American Occupational Therapy Association:

- Provides opportunities for entry into the profession at the masters degree level for those individuals qualified at the baccalaureate level in related behavioral and biologic science fields;
- Recognizes those occupational therapists educated in member countries of the World Federation of Occupational Therapists as eligible to sit for the AOTA Registration Examination;
- Qualifies military occupational therapy technicians with appropriate work experience as Certified Occupational Therapy Assistants;
- Recognizes those COTA's having adequate and relevant work experience as eligible to sit for the AOTA Registration Examination;
- Is actively engaged in a project to delineate the roles and functions of occupational therapy personnel to serve as the basis for the development of proficiency examinations at two entry levels.

The American Occupational Therapy Association acknowledges its responsibility for accountability for ongoing competence of practitioners bearing credentials for entry level performance. Thus, the AOTA is on record as supporting definite requirements of continuing education as a basis for ongoing recognition of competency of both OTR and COTA. Such standards are in the process of formulation.

Summary

In conclusion, AOTA believes in professional responsibility for standards of education and practitioner competency. It, however, recognizes today's need for various approaches to manpower qualification, modifying the concept of AOTA approved education as the sole criterion for practitioner recognition. It already has implemented several such alternatives and is in the process of studying and developing additional mechanisms for both initial recognition and ongoing competence. All these programs embody principles of equivalency and/or proficiency in concert with certain related basic education and experience.

Mobility and Articulation in Occupational Therapy The following statement was written by the occupational therapy members of the Discipline Advisory Group 1979-80):

Recognized levels of the occupational therapy profession are technical, baccalaureate and graduate. Accreditation and certification requirements must be considered in all articulation plans. A task force and a committee have been charged by the Representative Assembly of AOTA to study role delineation, educational requirements (The Essentials), and levels of entry into the profession. A report is due in 1981. Once these studies are completed, the development of articulation should be facilitated.

In order to increase the number of interested and qualified potential candidates to enter an occupational therapy training program at all levels--technical, baccalaureate and graduate--there needs to be established a method of articulation from pre-occupational therapy curricula programs and/or existing allied health programs. This would also serve as a mechanism for advancement of a student to his/her desired level of achievement. An articulated program would increase the avenue by which a student enters occupational therapy by allowing for transferability among similar allied health programs and expedite the educational process.

There presently exists in the state of Kentucky the possibility for articulating the following ways:

1.) transfer of students from pre-occupational therapy programs to the professional level of study;

2.) transfer of students from other pre-professional areas to professional levels of study;

3.) admission of certified occupational therapy assistant from existing certified occupational therapy assistants programs in other states to the baccalaureate level of study;

4.) transfer and admission of students from baccalaureate level occupational therapy program to and from baccalaureate level health programs;

5.) advance from the baccalaureate occupational therapy program in Kentucky and post-degree certificate programs in other states to graduate programs in other fields;

6.) advance from baccalaureate health programs to graduate occupational therapy programs in other states.

Based on the existing educational system in Kentucky, the only avenue for mobility into occupational therapy is at the baccalaureate level. Occupational therapists who need to obtain advanced competencies in occupational therapy must leave the state or transfer into another field.

"In 1971, the Delegate Assembly of the American Occupational Therapy Association (AOTA) adopted a resolution to develop procedures to provide the certified occupational therapy assistant (COTA) with an opportunity for career advancement without returning to a formal academic setting" (Adams, 1981). As a result the Career Mobility Program (CMP) was developed and "recognized that knowledge of and skills in occupational therapy could be developed through accumulated, related academic, clinical or practical experience" (Adams, 1981). Qualification criteria for the program were designed to allow, upon successful

completion of CMP, to take the Certification Examination for Occupational Therapist, Registered (OTR). The time, effort and money involved for each participant have been limiting factors for more COTAs to take advantage of the program. A follow-up survey of the 47 participants in the first 5½ years of the program indicated "that they appreciated having had the opportunity to participate in the CMP but would have preferred the traditional academic route to certification if it had been feasible" (Adams, 1981).

3 EDUCATIONAL CHALLENGES OF ARTICULATION IN PHYSICAL THERAPY AND OCCUPATIONAL THERAPY

Shortly after the physical therapist assistant was created to augment the roles and functions of the physical therapist, the implications were analyzed for education and practice (White, 1970). The APTA policy statement establishing this new level of practitioner was believed to support the articulation concept. Unfortunately evidence of this has not surfaced in twelve years. Cooperation among the faculty and administrators to establish transfer criteria for technical courses is critical if students time and money are to be effectively utilized. This challenge remains a primary goal of KAHP. With career mobility options available the potential applicant pool could increase for both levels of programs. Curriculum designs could be analyzed for their validity and articulated for more cost effective spending of education dollars by students and institutions.

Fundamentally the student is penalized for holding the desire and capability of advancement in physical therapy. Without the support of the profession and educational leaders physical therapy assistants who choose and are qualified to continue their education will remain a virtually untapped source of manpower. Careful planning and resource sharing is necessary to prevent any level of

program from compromising or burdening its academic quality for the purpose of articulation. However, this does not preclude the likelihood that articulated curricula could be designed and successfully implemented.

The greatest challenge occurs in dealing with "the tendency for allied health educators to be profession-centered rather than problem-centered" (Zimmerman, 1970).

> One concept is the Career Ladder, which proposes that a health profession be engineered so that an individual can enter the profession at any of the various levels, in any field, and then transfer laterally or advance vertically as far as his (her) abilities and interest take him (her). The second idea of an Educational Ladder is proposed as an undercarriage to the Career Ladder. The general goal expressed in the catch-phrase "Educational Ladder" is that training for the health professions should be totally integrated: each component of the system should have basic relevance to all other components. An individual's experience should enhance, not hamper, his ability to traverse career distances. It is of course, this concept of educational mobility that presents the allied health educator with his (her) most immediate challenge. All of the research we have on vocational choice and career development strongly indicates the need for flexibility...These needs demand an education that is totally cumulative without unnecessary loss of time or dollars. The goal is for a system where any educational experience has practical career-advancing relevance to all other educational experiences in the future. Unnecessary duplication or artificially imposed categories should not impede the ability or motivation of the individual to traverse distances between realistic career goals (Zimmerman, 1970).

The challenge in taking a position which philosophically supports quality educational programs with planned articulation is when it comes time to take action. The responsibility of programmatic and state planning includes objective, systematic analysis of the profession but also the future of higher education. Scattered attempts to adapt existing physical therapy curricula have resulted in the conclusion by some that the theoretical base required to function as a therapist is not nor should it be mandated at the assistant level.

The goal set forth by the Kentucky Allied Health Project is to find a way to plan the smooth transfer of technical skills (possibly in a modular

fashion) and focus on what needs to be done in the future to integrate the curricula rather than focus on what is and why it cannot be changed (Tomlinson, 1981).

Discipline Advisory Group Activities

1.) Existing Curricula. Activities completed by the Rehabilitation Therapy Discipline Advisory Group focused on the degree of articulation which already existed in Kentucky in the professions of occupational therapy and physical therapy, respectively. The group identified the curriculum outline for existing articulation in occupational therapy and physical therapy, respectively and designed a model that was aimed at reducing the extended time required for a physical therapist assistant to matriculate through the physical therapy program at the University of Kentucky. However, this did not address physical therapy related competencies overlapping from the associate degree to the baccalaureate degree. Simultaneously, the DAG developed "philosophy statements" reflecting their rationale for looking at articulation as they did. (These statements are presented in earlier sections of this report.)

2.) Issues and Recommendations. The Rehabilitation Therapy Discipline Advisory Group concluded the extent to which articulation existed in physical therapy and occupational therapy in Kentucky as of Spring, 1981 was optimal

given the professional indicators nationally and locally. Based on its study, the DAG identified the following barriers to articulation:

Barrier 1

There is a lack of specifically identified entry - level competencies of the PTA, the PT, and COTA and the OTR, respectively.

Barrier 2

There is not enough time in the two years of the PTA or the COTA program to meet the general education comonents of those programs, respectively, and also to satisfy the general education components and prerequisites of the PT or OTR program, respectively.

Barrier 3

The sequence of content and skill courses and/or units are offered over a two year period for the PT or OT student. The specific content is provided in a sequential building process based on the specific needs of the student at a specific point in time. The PTA or COTA courses and/or units are offered in a one year period with courses and/or units combined in a different manner to meet the specific needs of the PTA or COTA student at each point in time.

Barrier 4

There is a lack of incentive for faculty to make the changes identified for the PTA or COTA to articulate with the PT or OTR program, respectively, due (in part) to the small number of individuals (i.e. approximately 5% for PT) requesting or qualified for entrance into the PT or OTR programs, respectively.

Barrier 5

The mission statements of state supported educational institutions with identified geographic areas of influence has hindered the Jefferson Community College PTA program from functioning as a statewide program.*

Barrier 6

The general education and university requirements of each educational institution are unique to each institution.

Barrier 7

All educational institutions do not offer the prerequisites required by the PT program at the University of Kentucky or by the OT program at Eastern Kentucky University.

*The PTA program at JCC has a statewide mission.

Barrier 8

Not all colleges and high schools have counselors adequately familiar with the role, opportunity and need for PT or OT personnel and their educational requirements.

Barrier 9

The articulation of educational experiences of similar programs (PTA, PT, OT) is limited due to the development of these programs in separate institutions.

Barrier 10

The state supported educational system has not provided encouragement and/or resources for PT or OT to enhance their professional growth through graduate educational programs in the disciplines.

Barrier 11

The limited number of programs (one) and the limited number of COTAs and OTRs in Kentucky is a barrier to the study of occupational therapy in the state.

The DAG's discussion of these issues culminated in several recommendations to address each barrier (see Appendix C).

3.) Task Force Review. As a result, the Task Force of the Kentucky Allied Health Project responded to the Rehabilitation Therapy DAG's Final Report (1981) with the following statement:

> The Task Force appreciates the time and efforts taken by the Rehabilitation Therapy Discipline Advisory Group (DAG) to address these difficult problems and further we realize that these programs were not originally designed as steps in a laddered curriculum, however, irrespective of curriculum, programmatic, and philosophic considerations, the basic premise that assistant programs are terminal in nature is inconsistent with sound educational practice, the principles and philosophy of the KAHP project, and unacceptable to this Task Force. The philosophy of the KAHP is that articulation is possible and desirable. Although we realize that each of the professions have identified terminal behaviors for each of their levels, articulation between the two are desirable and feasible.
>
> The Allied Health Task Force recommends acceptance of the final report by the Rehabilitation Therapy DAG, but rejects the premise upon which the report is based. Further, we recommend that if financially possible, two outside consultants, who are recognized as having expertise in higher education curriculum and instruction, analyze the antithetical stances of the Task Force and the Rehabilitation Therapy DAG to determine which position is more educationally sound, and report their findings to the Task Force and the DAG. Finally, assuming that our position is correct,

the professional staff of the Council on Higher Education should cost out in realistic terms, the role delineation study necessary to implement the articulation project in Rehabilitation Therapy.

4.) External Consultation. Consequently, the DAG's Final Report was sent to two (2) outside consultants who had broad background in curriculum planning and development. They agreed to evaluate the Report and the Task Force's response by answering the following questions:

(1) What is the basic philosophy of education evident in the Rehabilitation Therapy Final Report?

(2) Is the Rehabilitation Therapy Final Report based on valid academic curriculum development and planning for the purpose of articulation?

(3) What are the specific strengths and limitations of the Rehabilitation Therapy Final Report?

(4) Based on your analysis of the Final Report, what are the strengths and limitations of the Task Force's response to the Report?

(5) Finally, what recommendations do you have to address the limitations of the Rehabilitation Therapy Final Report and/or the response from the Allied Health Task Force?

The consultant's responded to the strengths and weaknesses of the advisory group's final report. One consultant provided documentation supporting the position that quality educational programs could be planned with articulation integrated in the curricula (see Appendix D). Tomlinson stated "some institutions have found it to be possible to plan and deliver quality curricula in this area (rehabilitation) which give recognition to both institutional prerogatives and professional standards and also facilitate articulation. There has to be the willingness and incentive to initiate and carry out such planning...The DAG recommendations are most often made within the constraints of the existing situation and tend to reflect a predetermined position rather than an objective analysis with the purpose of facilitating articulation."

In Gilpatrick's response she states "the (DAG) Report appears to be evasive in its expression about desirability of articulation, but its net effect

is to oppose it..." She goes on to indicate "the limitations (of the DAG Report) are that there is evident confusion about what articulation implies, where the burden lies in carrying it out, and a foot dragging adherence to current conditions. It makes the problems seem more difficult than they are and avoids pointing out clear inequities in current practice... There are some real strengths (in the DAG Report), in that it makes manifest the attitudes that the state system must deal with if it is to succeed in enlisting support for articulation. It also provides needed information and several good suggestions."

5.) Termination of the DAG. No additional activities were planned by the DAG after January, 1981. The members elected to discontinue their meetings and did not wish to meet as a group to discuss the results of the consultants' evaluation. The DAG felt communication between the members was enhanced by KAHP and believed cooperative activities would increase.

Chances for articulation depended on improved data bases from which to assess comparable information between the physical therapist's assistant and the physical therapy programs. This was recognized as an important factor in determining whether or not articulation could actually be improved. The physical therapy assistant program agreed to develop a more comprehensive list of competencies for courses in the curriculum.

Physical Therapy Articulation Committee Activities

1.) Proposed Physical Therapy Program at the University of Louisville. In the Fall of 1981 the University of Louisville (UL), Division of Allied Health submitted a proposal to the Council on Higher Education for initiation of a new baccalaureate program in physical therapy. The proposal was based on sound principles of academic planning and included statements regarding the university's willingness and commitment to articulate the program with the

Physical Therapist Assistant Associate Degree Program at Jefferson Community College (JCC), also located in Louisville.

Prior to that time the Council had established specific criteria by which all proposals for new programs in public institutions would be reviewed. These review standards are quite extensive and address the many facets of statewide and program planning. However, for the purposes of this report two criteria are especially pertinent:

2.07 Plans for Articulation/Transfer Cooperation

a. Describe how this program will articulate with related programs in the institution and in the state.

b. Describe the extent to which student transfer has been explored and coordinated with other institutions.

3.02 Similar Program in Kentucky

d. Have you examined the possibility of collaborative and/or sharing of resources with similar programs within the state? What were the results of your examination?

Although the UL proposal documented a sound plan for a baccalaureate program and addressed the articulation issue, it lacked sufficient evidence of a viable mechanism for effective transition of qualified physical therapist assistants pursuing career mobility. This was brought to the attention of the University of Louisville which consequently formed an articulation committee to develop an agreement between the two levels of programs. Once the agreement was developed the Council on Higher Education approved the implementation of the physical therapy program.

2.) Articulation Committee. Administrators and faculty representing the UL proposed physical therapy and the JCC assistant programs comprised the committee. The initial meeting of this group served to identify the purpose of the group and plan for the acquisition of relevant data to share between the programs.

All the committee members were aware of the Rehabilitation DAG's conclusions which, among other things, suggested that the course objectives from the physical therapist assistant program needed to be more clearly defined and documented before an agreement could be developed.

3.) Negotiating the Transfer Agreement. The process used for negotiating this and other transfer agreements in allied health is illustrated in Figure 2.0.

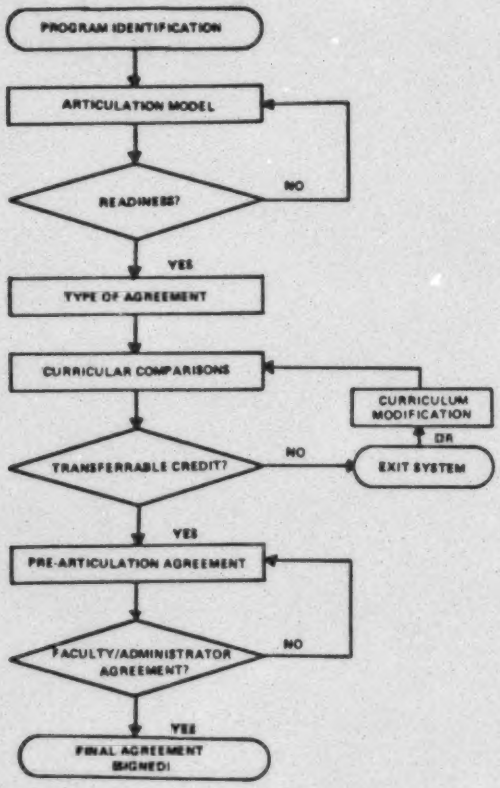

Figure 2.0. Process for Negotiating Transfer Agreements

Once the programs decided that a transfer agreement was desirable the following steps were completed:

1. Review respective curricula including course content and sequence. The curricular comparisons took a significant amount of time. However, the process laid the groundwork for developing cooperative and trusting relationships between the PT and PTA programs.
2. Mutually determine the existing amount of coursework/credit transferrable. A careful comparison of curricula resulted in the 1) identification of direct transfer credit for some general education and pre-professional course work, 2) identification of advanced placement credit (i.e. credit for professional related course work) and 3) the identification of other areas for cooperation.
3. Draft a pre-articulation agreement following the provisions for developing a transfer agreement. A "Checklist for Developing the Transfer Agreement" was designed to serve as a guide for writing the transfer agreement. Using the checklist and the previously identified transferrable course work/credits the first draft of the agreement was written for consideration and review by both programs. The draft became a working document for subsequent discussion and agreement.
4. Schedule a meeting between faculty and administrators to review and discuss the agreement. It was important for the individuals attending this meeting to be the faculty and administrators who would be instrumental in authorizing and implementing the agree-

ment and who knew the institutional policies and procedures that would influence the agreement. Because of the activities precluding the physical therapy agreement these individuals were involved in the entire process.

5. Secure authorizing signatures on final transfer agreement. The Articulation Committee identified the appropriate signatures required from both institutions to authorize the terms of the agreement and subsequently submitted the transfer agreement for approval.

Direct Credit Transfer

As a result of the Discipline Advisory Group and the Articulation Committee

1.) eight (8) general education courses (26 credits) in english, psychology, biology, math and sociology taught in the PTA program at Jefferson Community College can be transferred to the University of Louisville and the University of Kentucky physical therapy programs,

2.) upon advisement, potential transfer students may also take specified courses in chemistry (9 credits) and physics (10 credits) while at JCC to meet prerequisites for admission to the University of Louisville and the University of Kentucky physical therapy programs.

Advanced Placement Credit

Only UL has signed an agreement with Jefferson Community College to award advanced placement credit in eleven of its proposed courses, totaling fourteen credit hours (see Appendix E).

Areas of Cooperation

Specific to the UL-JCC agreement are conditions whereby

1.) clinical education experiences will be cooperatively planned,

2.) faculty from both programs will explore teaching selected components in each other's program,

3.) annual faculty/staff development meetings will be jointly planned, and

4.) an evaluation plan will be developed to determine the success of transfer students.

Physical Therapy Articulation with other Universities or Colleges

Preprofessional requirements to be completed prior to enrollment in the UL or UK physical therapy programs are identified to encourage students from other educational institutions to apply to their programs. A total of 60 semester credits are required to be eligible for enrollment and include:

2	Semesters of English
2	Semesters of Pyschology
2	Semesters of General Chemistry with laboratory
2	Semesters of General Physics with laboratory
2	Semseters of Biology or Zoology with laboratory (1 semester of comparative anatomy is recommended) Botany is not accepted
1	Semester of Sociology (University of Louisville only)

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APPENDIX A

Planning and Evaluation with PERT

Planning and Evaluation with PERT

Introduction

Planning and evaluation have been distinct challenges to persons writing proposals or implementing projects. One method for managing these challenges is the Program Evaluation and Review Technique (PERT).

PERT forced the identification of project activities that were necessary to reach the project goal and permitted evaluation of progress toward the goal. For example, when KAHP activities for the first year were planned and subjected to PERT, it was evident that failure to complete the activities in the amount of time prescribed was likely. A 68 percent probability of completing the first year activities was calculated.

Alternative solutions to the problem, as identified by PERT, were discussed by Council staff. Adjustments were made and the probability of completing the activities was elevated to 72 percent; however, the success of the project remained in doubt. Further adjustments were made and the probability of completing the first year activities increased to 95 percent.

Planning KAHP Activities

Project activities were identified and a Gantt chart was developed that depicted the activities of KAHP. Although the activities were identified and placed within time frames, the interrelationships among the activities were difficult to identify. Therefore, a "network" of activities was developed for the project. The network illustrated activities which were dependent upon other activities and activities which paralleled one another.

Three completion times, expressed in working day units, for each activity were estimated by Council staff: (a) most optimistic, (m) most likely, and (b) most pessimistic. A mean estimated time was then calculated for each of the three estimates per activity using the following formula:

$$T_E = \frac{a + 4(m)+b}{6}$$

The variance of the three mean time estimates per activity was calculated as follows:

$$V^2 = \frac{(b-a)^2}{6}$$

The critical path was the path requiring the largest amount of completion time. If sufficient amounts of time and resources were not available to complete the critical path, the success of the project was doubtful.

Several paths through the network were possible. The estimated times (T_E) for activities in each possible path were summed and a critical path (CP) was identified. The other paths were considered alternate paths.

Three methods to increase the probability of completing the activities were available:

1. Increase the time available to complete the project (TL).

2. Identify time and resources available in parallel activities that may be applied to critical path activities; thus, reducing the total time estimate for the critical path.

3. Plan to complete selected activities along the critical path in less time than estimated (i.e. reduce the estimated time).

During the project, Council staff applied the second method. The estimated time for an alternate path was subtracted from the estimated time of the critical path. The difference was "slack time" and "slack resources;" those resources were applied to another activity in the critical path; thus, the total estimated time for the critical path was reduced.

The adjustment increased the probability of completing first-year the activities 4 percent; however, the chance of success needed to be improved, if possible. The length of the critical path was further reduced by using the third method of increasing probabilities.

By planning to concentrate several Council staffs' efforts and by incorporating materials prepared throughout the initial months of the project, the estimated time was reduced.

The probability of completion was recalculated after shortening the critical path. By reallocating personnel and resources in an alternate path and by shortening the critical path estimated time, the probability of completing the first year activities, for example, was raised from 68 percent to 95 percent. Council staff were more confident that a successful project was possible. The technique was applied throughout the project.

Evaluating KAHP Activities

A process for evaluating the degree to which the specific project objectives and the project goal were reached was developed by utilizing the inherent capability of PERT, i.e. an evaluation procedure. Although the PERT evaluation procedure can be utilized at the conclusion of a project, staff decided to use a portion of the procedure periodically, as activities along the critical path were completed. Thus, continual monitoring of the project's status permitted identification of potential future trouble spots. The evaluation procedures were used for KAHP DAG, TAG, and Task Force objectives at the conclusion of year one and during the beginning of year three.

A formative interim evaluation of advisory groups' attitudes and accomplishments was requested by Dr. Elizabeth King, Associate Director for Allied Health Education and KAHP Director, in November, 1980. The results were used to help: 1) identify specific advisory groups' activities/ issues which needed attention, 2) plan the KAHP final year activities, and 3) identify activities which may continue beyond the funding cycle of KAHP.

Two evaluation designs were the foundations of all measurements. Attitudinal measurements were collected each time an advisory group met. The degrees to which advisory groups' activities were met were measured at the end of year one and during October-December, 1980 in the final year of KAHP.

Periodic evaluations of attitudes provided on-going feedback about each meeting to the KAHP staff and advisory groups. The instrument was administered at the conclusion of each meeting.

Output measures were: 1) the degree to which each advisory group's activities were accomplished, and 2) the advisory groups' attitudes. The groups' activities addressed the project's goals; attitudes were measured to assess the "climate" of the KAHP. Appendices are instruments used to collect data. The instruments were developed by the KAHP advisory groups and staff.

The schedule for attitude data collection paralleled DAG, TAG, and Task Force meeting dates (monthly). The instruments were administered by the KAHP staff at the conclusion of each meeting; each advisory group member completed an instrument. Interim activity evaluation instruments were administered in FALL, 1980 by KAHP staff at the regularly scheduled meeting or through the mail.

System Maintenance

At the conclusion of year three, staff identified activities which were necessary for the maintenance of A Statewide System for Allied Health Education. The PERT planning process was applied: (1) activities were identified, (2) a Gantt chart was constructed, (3) a network of activities was constructed, and (4) the times were estimated.

The probability of completing the activities can be calculated when the allowed completion time is determined. During system implementation, feedback from PERT evaluation procedures will provide formative evaluation data to the Council.

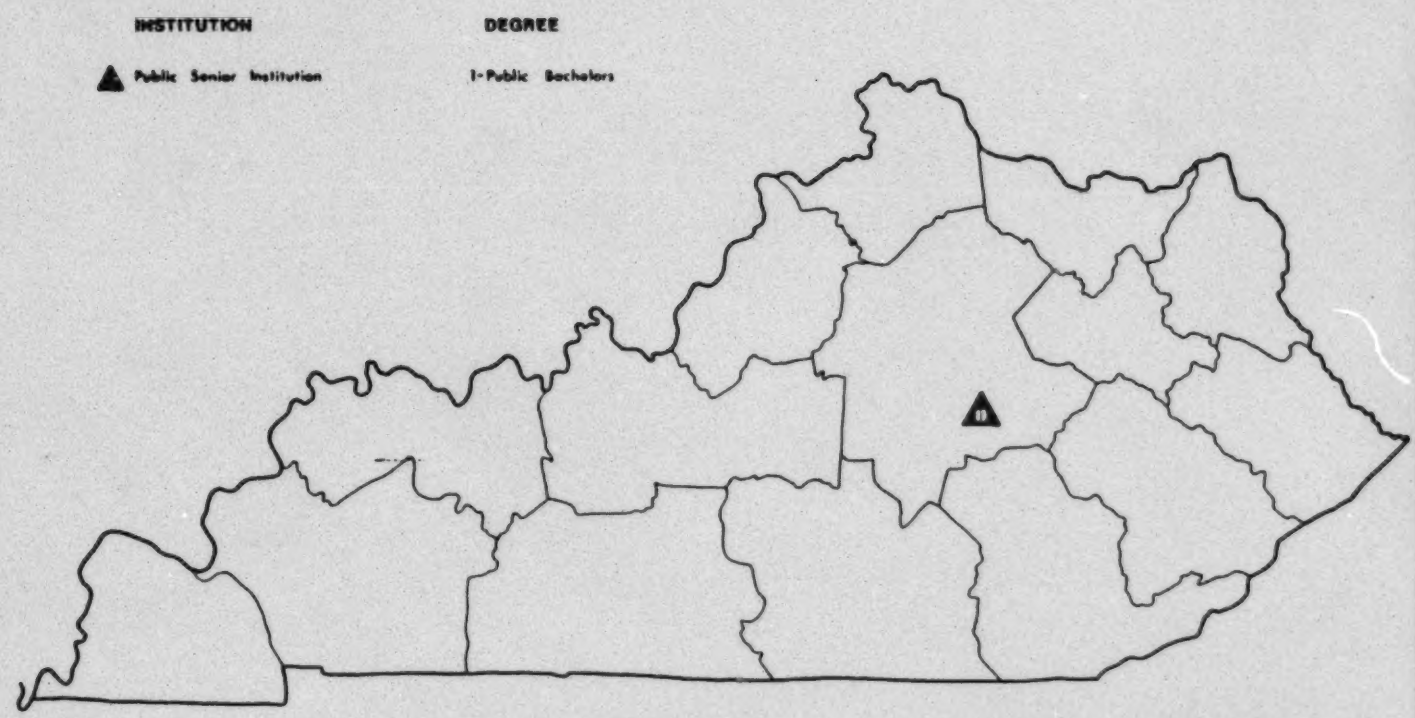
APPENDIX B

Program Inventory
and Maps Showing
Location of Programs

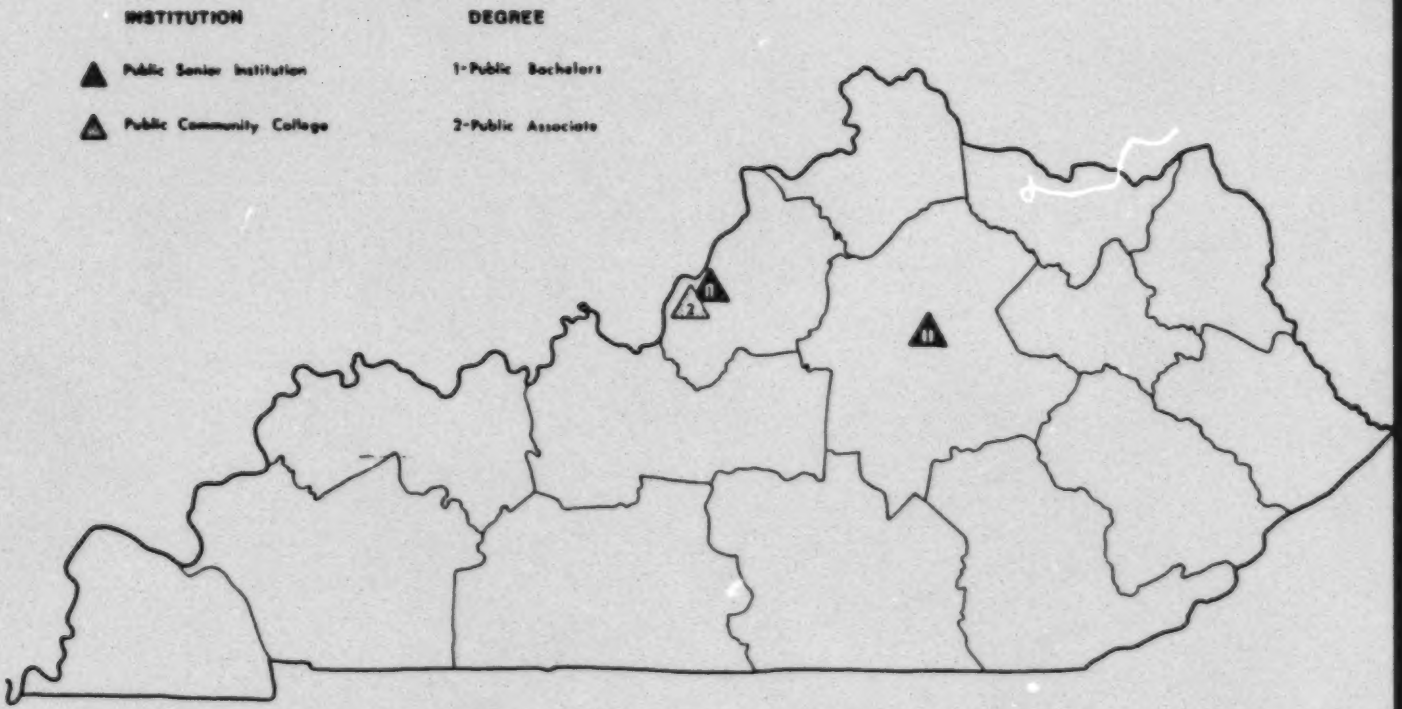
OCCUPATIONAL THERAPY AND PHYSICAL THERAPY
PROGRAM INVENTORY - KENTUCKY, 1982

INSTITUTIONS	Occupational Therapy (BS)	Physical Therapist's Assistant (AD)	Physical Therapy (BS)
Public Senior Institutions			
Eastern Kentucky University	X		
University of Kentucky			X
University of Louisville			X
Community College			
Jefferson Community College		X	
TOTAL	1	1	2

LOCATION AND TYPE OF SCHOOL OFFERING A PREPARATORY DEGREE IN OCCUPATIONAL THERAPY



LOCATION AND TYPE OF SCHOOL OFFERING A PREPARATORY DEGREE IN PHYSICAL THERAPY



APPENDIX C

Recommendations from the Discipline Advisory Group

RECOMMENDATIONS FROM THE DISCIPLINE ADVISORY GROUP

The Rehabilitation Therapy Discipline Advisory Group identified eleven (11) barriers to enhancing articulation. Consequently, the Group generated recommendations to help address the barriers:

ISSUE NO. 1 THERE IS A LACK OF SPECIFICALLY IDENTIFIED ENTRY - LEVEL COMPETENCIES OF THE PTA, THE PT, THE COTA AND THE OTR, RESPECTIVELY.

DISCUSSION

THE APTA AND THE AOTA ARE DEVELOPING DOCUMENTS RELATING TO "ENTRY-LEVEL COMPETENCIES" FOR THE PTA, THE PT, THE COTA AND THE OTR, RESPECTIVELY. THESE DOCUMENTS ARE UNDER DEVELOPMENT BY PROFESSIONALS WITH FAR MORE EXPERTISE THAN THE MEMBERS OF THE KAHP REHABILITATION THERAPY DAG. THE DAG MEMBERS FELT THEY DID NOT HAVE THE EXPERTISE OR TIME TO COMPLETE DELINEATION STUDIES WHICH DUPLICATE EFFORTS OF APTA AND AOTA, RESPECTIVELY. AN ESTIMATION OF AT LEAST ONE PROFESSIONAL FTE WOULD BE REQUIRED FOR AT LEAST 18 MONTHS PLUS SUPPORTING PERSONNEL AND RESOURCES.

RECOMMENDATION

1.1 Utilize the APTA Role Delineation Study results and wait for the completion of the other APTA and AOTA studies for subsequent data and recommendations.

1.2 An alternate plan would be to employ a person or persons to develop articulation of entry-level competencies specifically for Kentucky.

*Cost = $120,000
Time = 18 months

ISSUE NO. 2 THERE IS NOT ENOUGH TIME IN THE TWO YEARS OF THE PTA OR THE COTA PROGRAM TO MEET THE GENERAL EDUCATION COMPONENTS OF THOSE PROGRAMS, RESPECTIVELY, AND ALSO TO SATISFY THE GENERAL EDUCATION COMPONENTS AND PREREQUISITES OF THE PT OR OTR PROGRAM, RESPECTIVELY.

DISCUSSION

TIME IS NOT AVAILABLE TO MEET THE ADDITIONAL AND HIGHER LEVEL PREREQUISITES OF THE PT OR OT PROGRAM, RESPECTIVELY AS THE PTA AND COTA PROGRAMS CURRENTLY EXIST. THE TWO DIFFERENT LEVELS OF PROGRAMS (TECHNICAL AND PROFESSIONAL) ARE EDUCATING STUDENTS FOR

*See Barrier 4 for budget.

TWO DIFFERENT AND DISTINCT SETS OF TERMINAL BEHAVIORS. THEREFORE, THE TIME IT CURRENTLY TAKES FOR STUDENTS TO ARTICULATE REFLECTS THE DISTINCTION BETWEEN THE TWO LEVELS OF PRACTITIONERS AND NOT AN INABILITY TO ARTICULATE FROM ONE LEVEL TO THE NEXT.

RECOMMENDATIONS

2.1 Identify and Assist (New) students with the potential or desire to enter the PT or OT program to first enter a pre-PT or pre-OT program, respectively, versus a PTA or COTA program.

2.2 A student may acquire the necessary PT or OT prerequisites during summer sessions or through an additional year of education.

2.3 The PTA student can be guided through 6 semesters (2 years including summers) which will allow him/her to meet the PT prerequisites. Make the student aware of this option his/her freshman year and present to him/her other options.

ISSUE NO. 3 THE SEQUENCE OF CONTENT AND SKILL COURSES AND/OR UNITS ARE OFFERED OVER A TWO YEAR PERIOD FOR THE PT OR OT STUDENT. THE SPECIFIC CONTENT IS PROVIDED IN A SEQUENTIAL BUILDING PROCESS BASED ON THE SPECIFIC NEEDS OF THE STUDENT AT A SPECIFIC POINT IN TIME. THE PTA OR COTA RELATED COURSES AND/OR UNITS ARE OFFERED IN A ONE YEAR PERIOD WITH COURSES AND/OR UNITS COMBINED IN A DIFFERENT MANNER TO MEET THE SPECIFIC NEEDS OF THE PTA OR COTA STUDENT AT EACH POINT IN TIME.

DISCUSSION

THE TWO DIFFERENT LEVELS OF PROGRAMS (TECHNICAL AND PROFESSIONAL) ARE EDUCATING STUDENTS FOR TWO DIFFERENT AND DISTINCT SETS OF TERMINAL BEHAVIORS: THE PTA OR COTA HAS TO FUNCTION UNDER DIRECT SUPERVISION OF A PT OR OT, RESPECTIVELY. THE PT OR OTR IS AN INDEPENDENT FUNCTIONING PRACTITIONER. ARTICULATION CAN'T BE ACCOMPLISHED ANY MORE SMOOTHLY.

THE COMBINATION OF UNITS WITHIN COURSES IN THE PT PROGRAM DOES NOT MATCH SIMILAR COURSES OR UNITS IN THE PTA PROGRAM BASED ON THE NEEDS AND LEVELS OF COMPETENCY OF THE TWO HEALTH PERSONNEL. THE OVERLAP OF UNITS IS AS SMALL AS 15 MINUTES TO POSSIBLY AS MUCH AS 10 CLOCK HOURS. TO ACCOMMODATE ARTICULATION AND NOT HAVE A PTA STUDENT REPEAT MATERIAL WOULD MEAN A COMPLETE RESTRUCTURING OF ALL PT COURSES TO SPECIFICALLY MEET THE NEEDS OF THE PTA STUDENT (5%). THIS MAY REDUCE THE QUALITY OF EDUCATION OF THE NON PTA STUDENTS (95%) BY FORCING UNITS OUT OF SEQUENCE FOR THE EFFICIENCY OF THE PTA STUDENTS.

RECOMMENDATION

3.1 Continue with present program of permitting a PTA student to test out of units or courses. None of five PTA students who have enrolled in the PT program have requested this option because they stated the entire unit or course would be beneficial to them even though there may be some repeated content and skills. It is the opinion of the PT DAG members this is the most appropriate solution at this time.

3.2 Re-plan the PT curriculum to specifically accommodate the PTA students skills to reduce or eliminate the repeating of competencies already learned (roughly 20% of the PTA competencies are presented in a large number of PT courses).

Action -

The faculties of the two programs would need to identify every competency of the PTA and if and where that competency was taught in the PT program. The already learned competence skills and content could be pulled out of the PT courses and assigned to new or other courses to grant the PTA credit for the already learned competencies.

Time - 10 faculty x 5 days
Cost - 50 faculty days x $100 = $5,000 plus expenses, secretarial support, and lost faculty output

3. Freeze changes in PTA program so that the faculty of PT program are aware of the competencies expected of PTA students entering the PT program. If changes were made in the PTA program, similar changes would have to be made in the PT program to accomodate the addition or deletion of competencies of the PTA student to prevent duplication or ommission of the compentency in the PT program.

4. Other PTA programs approved in the state must prepare the PTA student with exactly the same competencies as the first PTA program to prevent duplication or ommission of competencies in the PT program.

5. The PT program would have great difficulty accepting a PTA student from an out of state PTA programs without doing a review of the competencies of each PTA program in order to accomodate the student without duplication of or ommission of competencies.

6. New PT programs in the state would have to offer the same competencies in same courses and sequence as the PT program at the University of Kentucky to be able to accomodate PTA students without duplication or ommission of competencies.

7. Each PTA and PT program would need to be provided similar resources (faculty expertise, labs, classrooms, equipment, etc.) to provide students with the appropriate competencies.

8. A statewide physical therapy coordinating committee would need to be developed to coordinate and negotiate course and program content and sequence to permit articulation.

ISSUE NO. 4 THERE IS A LACK OF INCENTIVE FOR FACULTY TO MAKE THE CHANGES IDENTIFIED FOR THE PTA OR COTA TO ARTICULATE WITH THE PT OR OTR PROGRAM, RESPECTIVELY, DUE (IN PART) TO THE SMALL NUMBER OF INDIVIDUALS (I.E. APPROXIMATELY 5% FOR PT) REQUESTING OR QUALIFIED FOR ENTRANCE INTO THE PT OR OT PROGRAMS, RESPECTIVELY.

DISCUSSION

IN THE OPINION OF THE FACULTY AND THE DAG, THE CURRENT ARTICULATION AND EDUCATIONAL PROCESS HAS GREATER BENEFITS TO A LARGER NUMBER OF STUDENTS THAN THE PROCESS THAT IS SUGGESTED BY KAHP.

FOR THIS SMALL NUMBER OF STUDENTS, THE COST AND DISRUPTION OF FINELY TUNED PT EDUCATIONAL PROGRAM SEEMS TO BE PROHIBITIVELY EXPENSIVE AND POSSIBLY CAUSE A LOSS TO THE 95% OF NON-PTA STUDENTS IN PT PROGRAMS.

RECOMMENDATION

4.1 The CHE and/or educational institutions could employ a person or persons to identify the necessary changes that would enhance articulation and structure programs to accomodate the changes while adhering to appropriate accreditation standards.

Proposed budget:

1 professional salary = 25,000 x 18 mos	=	$42,000
1 professional salary = 25,000 x 18 mos	=	42,000
1 secretary salary = 14,000 x 18 mos	=	21,000
Resources (mailing printing, telephone, etc.)	=	5,000
Travel (Consultants, faculty, clinicians)	=	10,000
TOTAL		$120,000

4.2 Educate faculty to the benefits of articulation through seminars or meetings.

4.3 Seek funds (loans, grants, traineeships) to initiate curricular changes.

4.4 Early identification and counseling of PTA students who have the desire and capabilities to be admitted to a PTA program.

4.5 Counsel PTA students to:
- A. Enroll in a pre-PT program,
- B. Enroll in summer sessions to acquire PT prerequisites,
- C. Enroll in 3rd year of education to acquire PT prerequisites and general education components.

4.6 Replan the PT program to specifically accomodate the PTA students skills to reduce or eliminate repeating competencies already learned (roughly 20% of the PTA competencies are presented over large number of PT courses).

4.7 Continue the present program of permitting a PTA student to test out of units or courses in the PT program.

ISSUE NO. 5 THE MISSION STATEMENTS OF STATE SUPPORTED EDUCATIONAL INSTITUTIONS WITH IDENTIFIED GEOGRAPHIC AREA OF INFLUENCE HAS HINDERED THE JEFFERSON COMMUNITY COLLEGE PTA PROGRAM FROM FUNCTIONING AS A STATEWIDE PROGRAM.

DISCUSSION

ACCEPTANCE OF STUDENTS HAS BASICALLY BEEN FROM THE INSTITUTIONS CATCHMENT AREA. GRADUATES HAVE BEEN EMPLOYED IN THE LOUISVILLE AREA, THEREFORE, NOT MAKING A MAJOR IMPACT ON STATEWIDE MANPOWER NEEDS.

RECOMMENDATION

5.1 If a PT, OT, PTA, or COTA program is the only program in the state, it should be stated when the program is approved, that an exception is granted to eliminate geographical limitations. Funding should reflect it is a statewide program.

ISSUE NO. 6 THE GENERAL EDUCATION AND UNIVERSITY REQUIREMENT OF EACH EDUCATIONAL INSTITUTION ARE UNIQUE TO EACH INSTITUTION.

DISCUSSION

A STUDENT MUST COMPLETE:

1) THE GENERAL EDUCATION REQUIREMENTS OF THE BASE INSTITUTION,

2) THE PREREQUISITES OF THE PT OR OT PROGRAM AT THE UNIVERSITY OF KENTUCKY OR EASTERN KENTUCKY UNIVERSITY, RESPECTIVELY,

3) THE GENERAL EDUCATION REQUIREMENTS OF THE UNIVERSITY OF KENTUCKY AND EASTERN KENTUCKY UNIVERSITY, RESPECTIVELY,

4) PLUS TRYING TO TAKE AS MANY COURSES IN A SECONDARY MAJOR IN CASE THEY ARE NOT ACCEPTED INTO THE PT PROGRAM AT UK OR THE OT PROGRAM AT EKU, RESPECTIVELY.

RECOMMENDATION

6.1 Encourage flexible requirements in the areas of general education.

6.2 Recommend all state supported university requirements come into alignment to enhance statewide planning and coordination for articulation in all programs, not just the rehabilitation DAG programs.

ISSUE NO. 7 ALL EDUCATIONAL INSTITUTIONS DO NOT OFFER THE PRE-REQUISITES REQUIRED BY THE PT PROGRAM AT UNIVERSITY OF KENTUCKY OR BY THE OT PROGRAM AT EASTERN KENTUCKY UNIVERSITY.

DISCUSSION

THE SIZE OF SOME EDUCATIONAL INSTITUTIONS (ESPECIALLY THE SMALLER COMMUNITY COLLEGES) PROHIBITS OFFERING THE VARIETY AND/OR SPECIFICITY OF COURSES REQUIRED OF A STUDENT TO COMPLETE THE PREREQUISITES FOR THE PT PROGRAM OR OT PROGRAM. THE COURSES THAT MIGHT NOT BE AVAILABLE ARE CHEMISTRY, PHYSICS AND COMPARATIVE ANATOMY - EACH WITH A LABORATORY.

RECOMMENDATION

7.1 If courses are not available:

- Identify pre-PT or pre-OT students and encourage them to transfer to an institution providing the prerequisites to the PT or OT program
- Enlarge the course offerings at these institutions to offer the basic science component for students desiring to transfer to four year institutions for a B.S. degree.

7.2 If the courses are available:

- Standardize prerequisite courses to a level of flexibility that would allow for rearranging the sequence so a student could follow a "prep course" which would allow various alternatives. (This approach may pose a threat to "academic freedom" as defined by faculty.)
- Concentrate on the similarities.
- Review prerequisites and recommend appropriate changes in course content.

- Recommend allowance of flexibility within institutions for waivers, "comp-out" and acceptance of substitute courses.

ISSUE NO. 8 NOT ALL COLLEGES AND HIGH SCHOOLS HAVE COUNSELORS ADEQUATELY FAMILIAR WITH ROLE, OPPORTUNITY AND NEED FOR PT OR OT PERSONNEL AND THEIR EDUCATIONAL REQUIREMENTS.

DISCUSSION

EDUCATIONAL INSTITUTIONS (COLLEGES AND HIGH SCHOOLS) DO NOT SEEM TO PLACE ADVISING AND CAREER COUNSELING OF STUDENTS AS A HIGH PRIORITY IN THE REWARD SYSTEM. IN ADDITION THERE APPEARS TO BE COMPETITION BETWEEN AND WITHIN EDUCATIONAL INSTITUTIONS FOR NUMBERS AND QUALITY STUDENTS.

RECOMMENDATION

8.1 The PT and OT programs should continue to identify potential pre-PT and pre-OT counselors, respectively, at all the other educational institutions.

8.2 Other educational institutions should develop pre-PT and pre-OT programs in coordination with the faculty at the University of Kentucky and Eastern Kentucky University, respectively, to increase the students awareness of opportunities available and the possibility of completing the first two years at an educational institution near home.

8.3 Increase the awareness of high school counselors of the opportunities in PT, OT, and PTA for students, and the high school background that would assist in a smooth transition to the first two years of college.

ISSUE NO. 9 THE ARTICULATION OF EDUCATIONAL EXPERIENCES OF SIMILAR PROGRAMS (PTA, PT, OT) IS LIMITED DUE TO THE DEVELOPMENT OF THESE PROGRAMS IN SEPARATE INSTITUTIONS.

DISCUSSION

IF BOTH PT AND OT EDUCATIONAL PROGRAMS WERE IN THE SAME EDUCATIONAL INSTITUTION, MANY EDUCATIONAL EXPERIENCES COULD BE SHARED. THIS IS NOT POSSIBLE DUE TO GEOGRAPHIC LOCATION AND LACK OF INSTITUTION AGREEMENTS ON CROSS REGISTERING STUDENTS AND SHARING STUDENTS FTEs.

RECOMMENDATION

Alternative A

9.1 Similar educational program (i.e. PT and OT) could be established or transferred to the same institution in order to:

a. conserve resources
b. provide more interdisciplinary experiences
c. improve offerings of same courses by virtue of larger numbers of students (i.e. anatomy, physiology, pathology, etc.)
d. enhance commonality of prerequisites
e. improve commonality of general education components
f. share teaching laboratories
g. improve continuing education offerings.

9.2 Graduate education programs could be shared in the areas of basic sciences, research laboratories, and teaching laboratories.

Alternative B

9.3 Develop an inter-university system to share FTEs, tuition, etc. to allow for cross registration.

9.4 Promote a statewide system to coordinate the administrative and financial issues which currently limit articulation.

ISSUE NO. 10 THE STATE SUPPORTED EDUCATIONAL SYSTEM HAS NOT PROVIDED ENCOURAGEMENT AND/OR RESOURCES FOR PTs OR OTs TO ENHANCE THEIR PROFESSIONAL GROWTH THROUGH GRADUATE EDUCATIONAL PROGRAMS IN THEIR DISCIPLINES.

RECOMMENDATION

10.1 Formal opportunities are needed to provide additional expertise for practitioners in the areas of clinical practice, education, research and administration.

10.2 Plan, initiate and establish graduate programs in physical therapy and occupational therapy to allow for upward articulation of physical therapists and occupational therapists. This would also provide additional faculty for expanding the existing education program and for an increase in the numbers of programs at the professional level.

ISSUE NO. 11 THE LIMITED NUMBER OF PROGRAMS (ONE) AND LIMITED NUMBER OF COTAs AND OTRs IN KENTUCKY IS A BARRIER TO THE STUDY OF OCCUPATIONAL THERAPY IN THE STATE.

DISCUSSION

IT'S DIFFICULT TO STUDY SOMETHING THAT IS NONEXISTENT ESPECIALLY WHEN THERE'S A LIMITATION TO STUDY ARTICULATION WITHIN THE STATE. THEREFORE, THE DAG WAS DEALING WITH HYPOTHETICAL SITUATIONS.

RECOMMENDATION

11.1 Wait for an increase in the number of OT programs.

11.2 Study other states (e.g. Tennessee) or combination of states.

APPENDIX D

Reports from External Evaluators
of the DAG's Report, 1981

University of Illinois at Urbana-Champaign

College of Education
DEPARTMENT OF VOCATIONAL
AND TECHNICAL EDUCATION

345 Education Building
1310 S. Sixth Street
Champaign, IL 61820
(217) 333-0807

September 22, 1981

Elizabeth C. King
Associate Director
Allied Health Education
Commonwealth of Kentucky
Council on Higher Education
1050 US 127 Bypass
Frankfort, KY 40601

Dear Associate Director King:

I have reviewed the Final Report of the Rehabilitation Therapy Discipline Advisory Group, the Response of the Allied Health Task Force to the Final Report and the paper entitled "Development of Articulation Models for Allied Health Statewide Planning."

Some preliminary remarks are appropriate for readers of this response. I have enclosed a reprint of an article I wrote more than ten years ago concerning articulation in the medical laboratory field. The model has many parallels for the Rehabilitation Therapy field. This article and other writings and activities provide evidence of a philosophical position in support of quality educational programs with planned articulation on both horizontal and vertical dimensions.

An analysis of the paper "Development of Articulation Models...", reveals choices of words and relative emphases which bear directly on the antithetical stances of the DAG and the Task Force. Far greater emphasis is given in the paper to articulation within levels of a field in comparison articulation across levels (e.g., 1) in the abstract "The primary goal ... was to develop ... within each level and type of program ...". No mention is made of across levels. 2) under Goals and Objectives (Pg. 4) no mention is made of moving from Associate degree to B.S. degree. From other materials and contacts, I am aware that the philosophical position of the Task Force is to achieve vertical mobility. However, if other materials reflect relative positions similar to the Articulation Models paper, there is at least some basis for the stance taken by the Rehabilitation Therapy DAG.

I have been asked to respond to five specific questions. They are:

(1) What is the basic philosophy of education evident in the Rehabilitation Therapy Final Report?

It is significant that this DAG presents neither a statement of philosophy for Rehabilitation Therapy per se nor does it relate the Final Report to the philosophy and objectives of the KAHP project. Separate statements are presented for each of PT and OT. The schema presented on Page 3 is illustrative of the full report: there is essentially no articulation between OT and PT or between levels within each of these fields.

The philosophy of education of the group must be derived from the statements and omissions of the Report itself. The Report "... presents the current curricula ... (and then) ... it was generally agreed ... that a more clear-cut mechanism for articulation is not feasible at this time." The focus is almost entirely on what is and why it cannot be changed rather than on what could be, should be or needs to be done in the future.

The DAG relies on a very narrow basis for its considerations, primarily the three existing programs. Essentially no evidence or consideration is reported for the needs for health care in the state or region, of the potential students or for state agencies (including higher education) to achieve efficiencies with limited resources.

(2) Is the Rehabilitation Therapy Final Report based on valid academic curriculum development and planning for the purpose of articulation?

The Report, consistent with statements within, essentially reviews the current status of the three programs; curriculum development and planning for the purpose of articulation is not addressed beyond the existing limited possibilities.

The recognition that the identification of needed competencies is an essential step for both developing curricula for practitioners and for articulation is a valid basis for planning. Academic curriculum development is dealt with by asserting that it is an individual institution prerogative. Professional practice components and prerequisites are similarily allocated for determination by the Professional associations in each of the two fields. It is recognized that both of these principles have a legitimate role. However, each can be met in a variety of legitimate ways and neither is absolute. The two positions in the extreme are in conflict.

Some institutions have found it to be possible to plan and deliver quality curricula in this area which give recognition to both institutional prerogatives and professional standards and also to facilitate articulation. There has to be the willingness, and incentive, to initiate and carry out such planning.

(3) What are the specific strengths and limitations of the Rehabilitation Therapy Final Report?

The basic limitations are cited in response to questions 1 and 2. Other specific limitations stem from the more general ones.

One additional limitation should be cited. The on-going studies of tasks and role delineation by each of the PT and OT associations are cited in several places as a basis for delaying considerations in this area. Materials included in the Report indicate that the surveys for the PT field had been concluded some months before. It is quite common for preliminary results to be at least partially available well before a final report is made. In addition, other previous studies in the field are available. It is unlikely that the currrent PT study will make major changes. The AOTA (letter dated June 25, 1980;

pg. 85) reports that the prior role delineation studies are adequate and no new study is justified or underway.

The Final Report does have a number of strengths. The greatest strength is the identification of the Barriers to articulation. This reviewer has no basis for questioning the existence of these barrier and would be surprised if many of the type cited had not been found.

Many of the Reason for the Barrier statements reflect at least some degree of study of the situation. Some statements included in the Reasons raise questions about the objectivity of the study e.g. for Barrier 3, "Articulation can't be accomplished any more smoothly."

The DAG Recommendations are most often made within the constraints of the existing situation and tend to reflect a pre-determined position rather than an objective analysis with the purpose of facilitating articulation.

Barrier 4 and 5 contain some elements that will most likely have to have attention if articulation in this field is to be achieved. It is not difficult to understand why only 5% of the PTAs or COTAs have advanced under the existing conditions. A more important question is how many would if better articulation mechanisms were in existence.

The question of faculty incentive and willingness is critical. To achieve truly articulated programs it may be necessary to establish new programs at a different institution(s) and provide the appropriate incentives along with supporting changes in institutional mission statements. This action may also have to be supported by some shifting of resources.

(4) Based on your analysis of the Final Report, what are the strengths and limitations of the Task Force's response to the Report?

The statement of the philosophy and mission of the Task Force is succinctly and clearly stated.

Based on this philosphy, the action taken, to reject the premise and therefore the recommendations of the DAG, appears to be the only possible response.

The real question is not which stance, the DAG or the Task Force, is the more educationally sound. Rather it is: Is it possible to develop educationally sound programs which will facilitate articulation in this field and will such programs better meet the needs of Kentucky?

There is little evidence in the Final Report which relates directly to the latter question. There is a body of literature which suggests that an affirmative answer is possible.

(5) Finally, what recommendations do you have to address the limitations of the Rehabilitation Therapy Final Report and/or the response from the Allied Health Task Force?

The recommendation of the professional staff of the Council on Higher Education to cost out a role delineation study does not appear appropriate at this time. What would be done with the result of such a study?

It would appear that the faculty at the institutions which now have programs in the two fields do not recognize the existence of a Rehabilitation Therapy field nor do they feel that they could make modifications within their separate programs to facilitate vertical or horizontal articulation. The existence of a definitive role delineation study would likely have little impact on the existing programs if the Final Report is a reflection of existing philosophy.

Under the circumstances, it would appear that the Commission on Higher Education will have to make a fundamental decision on direction. If articulation is a primary goal, the Commission will have to decide whether it is more likely to achieve this goal with changes in the existing programs or with a new program(s) at a new location(s). Any further expenditures should be made following this decision and be directly in support of that decision. Comments under question 3 should be given consideration in the decisions.

Summary Remarks

I was not aware of the situation to which I would be asked to respond when I agreed to review one of the DAG Final Reports. I was familiar with the DAG process as a part of the larger Project. However, as a matter of principle, once an assignment is accepted I feel there is a professional obligation to carry it out in an objective and professional manner. I have attempted to do so in this response.

The views of an "outside neutral" party can sometimes provide assistance in resolving differences. However, it must also be recognized that those outside do not have knowledge of many factors that must be taken into account in the final decisions. Even when all the factors are known there is room for honest and legitimate disagreement and differences in position. In the final analysis any achievements in this area will have to be made by those in Kentucky. I can only hope that the effort reflected in this response contributes to moving forward with achievements.

Sincerely,

Robert M. Tomlinson

RMT/em

Enclosure

RESPONSE TO THE CHARGES GIVEN TO CONSULTANT
E. Gilpatrick

1. The Basic Philosophy of Education Evident in the Report.

The conclusion that "a more clear-cut mechanism for articulation is not feasible at this time," does not suggest a philosophy sympathetic to articulation objectives. "At this time" life exists as it is. The issue is whether a more clear-cut mechanism for articulation is feasible in the near future, and whether it is desirable, equitable and able to be implemented.

The Report appears to be evasive in its expressions about desirability of articulation, but its net effect is to oppose it through its representation of material and its over-all tone. However, it is fair to reserve these comments for the physical therapy sections generally, since these are the only practical issues, and physical therapy dominates the statement of issues and related recommendations. Enclosure I speaks more directly to this question.

2. Validity of Academic Curriculum Development and Planning for the Purpose of Articulation.

The Final Report in no way reads as though its charge was to develop and plan for articulation. By deferring to ongoing role and function delineation studies, to be completed by professional associations, it sidesteps the mandate. I agree that a proper analysis is worth waiting for. (See my cover letter). However, as Enclosure II will demonstrate, much analytic work could have been done. Enclosure III indicates how little there is to work with in occupational therapy, however.

3. Strengths and Limitations of Final Report.

The limitations are that there is evident confusion about what articulation implies, where the burden lies in carrying it out, and a foot dragging adherence to current conditions. It makes the problems seem more difficult than they are, and avoids pointing out clear inequities in current practice. See Enclosure II. Even the suggestions are made to seem so difficult as to be unrealizable. There are some real strengths, in that it makes manifest the attitudes that the state system must deal with if it is to succeed in enlisting support for articulation. It also provides needed information and several good suggestions. See Enclosure IV.

4. Strengths and Limitations of Task Force Response.

I fully support the position of the first paragraph of the response. It is gutsy, honest, and its clear right to hold to its philosophy. Articulation is possible and I agree that it is desireable. See enclosed working paper #11. Support for terminal education is not explicitly given, however, in the Final Report. I do not agree that the Final Report should be accepted even if the premise is rejected, because it is inadequate even given the limitations.

I cannot argue which stance is more educationally sound. It is a matter of educational objectives. If the object is to provide for stable manpower pools, then terminal education is desirable. If the objective is to provide for maximum professional understanding and occupational mobility, then articulated education is desirable. These are social choices.

5. I recommend considering my proposed articulation plan in Enclosure II.

I recommend reconstitution of the DAG with individuals committed to articulation; and a conference of employers and educators, related to the programs, to respond to suggestions such as in Enclosure II.

I recommend use of HSMS methodology if time and money permit, or critical use of the results of the ongoing studies.

Of the DAG recommendations I suggest or agree with the following; I disagree with most of the other suggestions:

- Replan the PTA curriculum to specifically overlap whole courses which correspond to necessary overlap in functions of PTA's and PT's. See EnclosureII.
- Continue to allow current PTA's to challenge test. In future, allow for exemptions based on true overlap. Out-of-state PTA's could continue to challenge test.
- Standardize PTA programs.
- Only one PT program is needed to provide articulation unless enrollment numbers grow.
- Create a coordinating committee for implementation in the cooperating schools.
- Send committee to meet with Ferris State College in Michigan to see how they do it with two and four year programs.
- The JCC PTA program should be made to support statewide needs.
- Encourage use of standardized, minimum requirements relevant to occupational performance for pre-professional and assistant programs, and flexible requirements in other general education disciplines.
- Page 52 - I agree
- Page 53 - Useful, but what about employing a visiting career counselor in rehabilitation--knowledgeable about the requirements, sequences, options and locations of programs? Cheaper than one for each school. One for high schools useful too!

- Page 54 - I agree

- Page 55 - I agree - Also, consider combined PT-OT advanced degree in Rehab.

- Page 56 - Study the need for OTA program and design it to articulate with a receptive OT program in an area where employers are receptive and can make inputs in the planning. Design the occupational sequence in jobs and check that they will be accepted by employers before you pour resources into programs!

- See my comments written on the Final Report pages.

6. Task analysis, involving skill and knowledge requirements, to delineate and compare occupational roles and functions and to design sequenced, articulated, professional education can settle most of the questions raised in the Report. However, implementation of the results of such analysis requires acceptance from the employers of the would-be new occupational structures, as well as willingness by the educators to redesign painstakingly educational programs to correspond with occupational practices.

   Job-relevant education, to be achieved, impinges on the freedom of educators to be entrepreneurs in their classrooms--with each course what its teacher decides it will be. That freedom is precious--but it is a good when it supports desirable trends; it is an evil when it supports outmoded information and practice.

Enclosure I.

Introduction and Philosophy Statements of the PT Subcommittee

"Letters supporting the Group's philosophy and current curricula were obtained...." (p. 3 of Report).

The Report appears to be either a defensive, obstructionist smoke screen to defend the status quo, or a less than careful reading of the materials. Based on the letters shown in the Appendixes, three in the PT-PTA area and three in the OT-OTA area are relevant. Of the total, four support articulation -- but point out the problems. Only two are against. In PT-PTA, we find the two against, leaving only one for. But this hardly constitutes support for the Group's philosophy and current curricula.

It is apparent that the concepts needed to implement laddering, or articulation, are not clearly grasped. Core courses, joint courses, and overlap courses are not desirable in and of themselves. A career ladder implies that different but related work is done at each level; that the higher job level requires deeper preparation in content introduced at less depth at the lower job level -- plus new skills and knowledge. Overlap of tasks necessary to both job levels would permit some course work to be introduced early and not repeated. The efficiency of career laddering is that lower job level candidates do not have to repeat work to move ahead, do not take irrelevant work to exit to jobs, and need not do more total course work to move up than those who go straight to the upper level. This is only possible if lower job level courses are taught with an eye to future education, while remaining job relevant. Upper level schools assist this if courses are taught in units that make exemptions possible.

In current practice, the use of academic prerequisite courses for associate and baccalaureate programs is an efficient (an all too efficient) screen for academic abilities. If associate programs use general science and humanities courses this way, they should at least make sure that AA college courses are those needed to enter BA & BS professional programs. The best approach would be to require only those college disciplines really related as enabling content to the AA level job content along with the technical material. The remaining prerequisites for the professional program can then be required. This would let the student who "washes out" of the academic "hard" courses, exit to the AA level job.

Let us remember the reasons that students need career laddering. It is not to have "feeder" programs that one takes one after another. It is to permit students with real financial pressures to earn income to study, work, and return to study and career advancement without the time and money penalty of essentially "starting over." This is a waste of time, money, and educational resources.

It is also to give an individual who discovers a desire to advance or an ability to do college work later in life a chance to come back and continue -- without penalty.

It also gives students who need to feel the real world by working -- a breather -- before returning.

We need to be realistic about the pressures against implementation of educational-career ladders:

1. In PT, for example, unless there is a critical shortage of Physical Therapists, PTA's with mobility are a threat.

   a. A hospital can hire a Physical Therapist and two PTA's a lot cheaper than three Physical Therapists. Since it is the MD's who do the prescribing in the hospital setting, the PTA is an attractive alternative. It is in the interest of the PT (short view) to keep the PTA program technical, narrow, and thereby inadequate for articulation.

   b. To the extent that Physical Therapists win their fight to become the prescriber's (see Appendix B, pp. 64-65) and out from under MD control, the PTA becomes an important employee of the PT in private practice. In this situation, the PT doesn't want to risk a high turnover in staff, with the existing employee setting up for competing practice next door. That seems to lie behind the letter from Ms. Canan (pp. 70-72).

2. It is my experience that the PTA to PT issue is similar to the Practical Nurse (PN) to Registered Nurse (RN) issue, now that we have PN one-year, AA two-years, and BS four-year programs. The same arguments abound in nursing about the need for technical personnel. But it may not escape attention that one and two-year programs attract poor people who cannot spend time in higher education without income. Poverty does not mean inability to do college work. It also seems to be the experience that poverty and color go hand in hand. So the number of black students dwindles as we go up the ladder. If articulation means that working students get a chance to advance, the racial composition of the professions will change. Not everyone wants to encourage such change.

3. The Report uses the figure of 5 percent as the number of PTA's who apply to PT programs. Is this the national figure or the one at University of Alabama? (See p. 71.) In any case, rather than being a discouraging figure, one must applaud the dedication of these students who put in one to two more years of coursework than those who go straight to PT work--with no encouragement. There is no way to know what the enrollment would be for a truly articulated

program. It would be more than 5 percent, but it would come into being after graduates of a new set of requirements were out and working as PTA's. Because articulation means exit and later reentry.

- Does the state of Kentucky want to invest in supporting the program until then? I hope so.

- It is in the interests of educational efficiency, personal freedom, and quality patient care to have motivated health professionals with choices and horizons open to them. The Report suggests that it is too hard to get that. I challenge that conclusion.

APPENDIX E

Transfer Agreement
Between Jefferson Community College
and University of Louisville

Conditions of Agreement for Transfer of Credit and Cooperation between the Physical Therapist Assistant Program at Jefferson Community College and the Physical Therapy Program at the University of Louisville

Conditions of Agreement for Transfer of Credit

According to the conditions of this agreement Physical Therapist Assistant graduates from Jefferson Community College can transfer to the Physical Therapy Program at the University of Louisville.

(1) Upon formal documentation of completion of the Physical Therapist Associate Degree Program at Jefferson Community College and successful completion of the required preprofessional course work for the Physical Therapy Program, these graduates will be eligible for admission to the Physical Therapy Bachelor Degree Program at the University of Louisville.

(2) Successful completion of the Physical Therapist Associate Degree program is defined by the current standards of the program; if requirements for graduation at either program change the other program is to be notified and the conditions of this agreement reviewed.

(3) Graduates from the Physical Therapist Assistant program shall be subject to the same admission and academic policies as all applicants to the University of Louisville program.

(4) Jefferson Community College graduates admitted to the Physical Therapy program at the University of Louisville shall be awarded direct transfer credit and advanced placement credit as follows:

Direct Transfer Credit

English 101 Freshman Composition	3
English 102 Advanced Freshman Composition	3
Psychology 111 (100 or 110) Basic Psychology	3
Psychology 112 (or 223) Basic Psychology	3
Biology 110 (Anatomy and Physiology I)	4
Biology 111 (Anatomy and Physiology II)	4
Math 151 Applied Mathematics I or Math 109 College Algebra	3
Sociology 101 Introductory Sociology	3
	26

*Chemistry 105	General College Chemistry I	3
*Chemistry 107	General College Chemistry II	3
*Chemistry 115	Laboratory	3
		9

*Physics 211	General Elementary Physics	5
*Physics 213	General Elementary Physics	5
		10

*Not typically taken, taken under advisement for potential transfer students. Required prerequisites for admission to the University of Louisville Physical Therapy Program.

Advanced Placement Credit

AHC 320	Health Care Delivery in the U.S.	2
AHC 300 A	Medical Terminology	1
AHC 300 B	General Patient Care and Ethics	1
AHC 300 C	Emergency Medical Procedures	1
*AHC 311 A	Psychological and Social Aspects of Health and Illness	1
*AHC 311 B	Psychological Aspects of Illness and Disability	1
AHC 311 C	Interpersonal Relationships For Allied Health Practitioners	1
AHC 301	Massage	1
**PT 321	Physical Therapy Modalities	1
***PT 414	Medical Science	3
****PT 440	Therapeutic Exercise I	1
		14

*An experimental course will be developed at JCC and team taught by JCC and UL faculty (i.e. PTA 239). The course will include the objectives within AHC 311A and AHC 311B; U of L will transfer 2 credit hours.

**UL will redevelop PT 321 with an emphasis on theory and application. U/L will transfer the application portion of the course (i.e. 1 credit hours).

***Pre-identified potential transfer students at JCC may register for this course at U/L during their second year at JCC.

****This course will be developed into modules; the module(s) containing Range of Motion, Strengthening Exercises, Berger Allen Exercise, Relaxation Exercises, and Respiratory Exercises will be given advanced credit for PTA students. However, PTA students will be required to attend all labs. Mini-lectures will be presented before each lab.

Direct transfer credit and advanced placement credit as specified by this agreement shall be awarded to individuals who have graduated from the Jefferson Community College Physical Therapist Assistant Program since May, 1981. Individuals who graduated prior to May, 1981 will have their transcripts evaluated on an individual basis.

(5) The Jefferson Community College Physical Therapist Assistant program shall provide guidance and counseling for students interested in transferring to the University of Louisville and make known the conditions of this agreement to students/graduates of the Physical Therapist Assistant program.

The University of Louisville shall identify a faculty member within the Physical Therapy Program to serve as an advisor for transfer students. In addition, JCC and UL faculty members responsible for guidance and counseling will jointly develop a transfer guide sheet.

(6) If either part wishes to modify this Agreement, it is understood that students who have already transferred to the University of Louisville will have the opportunity to complete their program under the conditions of this agreement.

(7) Grievances from any party associated with or influenced by these conditions of agreement shall be made known to and addressed by the appropriate departmental and/or administrative level for discussion of implications of the grievance in order to revise/amend these conditions of agreement as decided by both programs.

(8) These conditions of agreement shall be deemed invalid without the authorizing signatures representing Jefferson Community College and the University of Louisville.

(9) The conditions of this agreement shall be reviewed annually to determine if any additional transfer of credit is possible. Based upon this review the agreement will be revised or amended as agreed upon by both programs.

(10) Each program retains the right to change their curriculum and agrees to inform the other program of such changes as related to the conditions of this agreement.

Areas for Cooperation

(1) Jefferson Community College and the University of Louisville will plan cooperatively for the clinical education experiences for both the Physical Therapist Assistant students and the Physical Therapy students.

(2) Faculty from both the Physical Therapist Assistant program at JCC and the Physical Therapy program at UL will explore the possiblities of teaching selected components in each other's program.

(3) A jointly planned faculty/staff development meeting will be held annually to familiarize both faculties with the provisions and conditions of the agreement.

(4) An evaluation plan will be developed to determine the success of the transfer student.

I hereby accept the conditions of this agreement for transfer of credit for graduates from the Physical Therapist Assistant Program at Jefferson Community College to the Physical Therapy Program at the University of Louisville.

Director Jefferson Community College	Date
Physical Therapist Assistant Program Chairman Jefferson Community College	Date
Special Assistant to the President for Health Affairs University of Louisville	Date
Physical Therapy Department Chairman University of Louisville	Date
Vice President, University of Kentucky Community College System	Date